A HELIX OF ANXIETY: A QUALITATIVE ANALYSIS OF THE PERSONAL EXPERIENCES OF INDIVIDUALS WITH HEALTH ANXIETY

A THESIS SUBMITTED TO
THE GRADUATE SCHOOL OF SOCIAL SCIENCES
OF
MIDDLE EAST TECHNICAL UNIVERSITY

BY

BURCU PINAR BULUT

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY
IN
THE DEPARTMENT OF PSYCHOLOGY

OCTOBER 2019

Approval of the Graduate School of Social Sciences

Prof. Dr. Yaşar Kondakçı
Director

I certify that this thesis satisfies all the requirements as a thesis for the degree of Doctor of Philosophy.

Prof. Dr. Sibel Kazak Berument
Head of Department

This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Doctor of Philosophy.

Prof. Dr. Özlem Bozo Özen
Supervisor

Examining Committee Members

Prof. Dr. Bengi Öner Özkan	(METU, PSY)	
Prof. Dr. Özlem Bozo Özen	(METU, PSY)	
Assoc. Prof. Dr. Hatice Demirbaş	(A. Hacı Bayram Veli Uni., PSİ)	
Assist. Prof. Dr. Dilek Demirtepe Saygılı	(Atılım Uni., PSY)	
Assist. Prof. Dr. Gaye Zeynep Çenesiz	(Van Yüzüncü Yıl Uni., PSİ)	

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last name: Burcu Pınar Bulut

Signature:

ABSTRACT

A HELIX OF ANXIETY: A QUALITATIVE ANALYSIS OF THE PERSONAL EXPERIENCES OF INDIVIDUALS WITH HEALTH ANXIETY

Bulut, Burcu Pınar
Ph.D., Department of Psychology
Supervisor: Prof. Dr. Özlem Bozo Özen

October 2019, 140 pages

The mind-body problem dates to old times. Hypochondria is at the center of the discussions about the psyche-soma relationship since it appears that individuals have physical complaints in the absence of "real" illness. The current study aimed to explore how individuals having hypochondriac complaints interact with their bodies and their experiences regarding the believed illness or anxiety about the illness. Furthermore, the way they establish a relationship with others, especially with physicians, other healthcare professionals, and with whom they try to get assurance was tried to be understood. Interpretative phenomenological analysis (IPA) was used as a method since it offers a systematic approach to study the subjective experiences of individuals by making a very detailed examination of a case. The fourteen participants between 19-55 years old, who were living in Ankara, whose questionnaire scores indicated high health anxiety and who also stated that they have anxiety about their health were included in the study. The data of the study were collected via face to face semi-structured interviews. As a result of the analyses of these interviews, four superordinate themes emerged. 'Causal attributions of health anxiety: loss at the core as an unsettled matter', 'Being drawn into the vortex of the symptom', 'An endless call to an expert for naming own experiences and eliminating uncertainty', and 'Every cloud has a silver lining: Benefits of being/feeling ill' were the themes. These themes and the clinical implications of the findings were discussed in the light of the literature.

Keywords: Hypochondria, Health Anxiety, Somatization, Interpretative Phenomenological Analysis

ÖZ

KAYGI SARMALI: SAĞLIK KAYGISI OLAN BİREYLERİN KİŞİSEL DENEYİMLERİNİN NİTEL BİR İNCELEMESİ

Bulut, Burcu Pınar
Doktora, Psikoloji Bölümü
Tez Yöneticisi: Prof. Dr. Özlem Bozo Özen

Ekim 2019, 140 sayfa

Zihin-beden problemi eski zamanlara dayanmaktadır ve hem felsefenin hem de modern bilimin alanına girmektedir. Hipokondriya, ruh-beden ikilemiyle ilgili tartışmaların merkezinde yer almaktadır çünkü bireylerin “gerçek” bir hastalıkları olmasa dahi fiziksel şikâyetleri vardır. Bu çalışma, hipokondriyak şikâyetleri olan bireylerin bedenleriyle nasıl ilişki kurduklarını ve kendilerinde olduğunu düşündükleri hastalığa ya da hastalık kaygılarına ilişkin deneyimlerini araştırmayı amaçlamıştır. Ayrıca, bu kişilerin diğer kişilerle, özellikle de doktorlarla, diğer sağlık profesyonelleriyle ve güvence aradıkları kişilerle nasıl ilişki kurdukları anlaşılmaya çalışılmıştır. Yorumlayıcı fenomenolojik analiz (YFA), bir olgunun ayrıntılı bir incelemesini yaparak, bireylerin öznel deneyimlerini incelemek için sistematik bir yaklaşım sunduğu için araştırmanın yöntemi olarak kullanılmıştır. Çalışmanın katılımcıları, 19-55 yaşları arasında, Ankara'da yaşayan, anket puanlarına göre sağlık kaygıları yüksek olan ve sağlık kaygılarının yüksek olduğu kendileri tarafından da rapor edilen 14 kişiden oluşmaktadır. Çalışmanın verileri yarı yapılandırılmış görüşmelerle yüz yüze toplanmıştır. Bu görüşmelerin analizleri sonucunda, 'Sağlık kaygısına yapılan nedensel atıflar: Halledilmemiş bir mesele olarak kayıp', 'Semptomun girbadına sürüklenmek’, 'Deneyimlerini adlandırması ve belirsizliği ortadan kaldırması için bir uzmana yapılan sonsuz çağrı’ ve 'Her şerde bir hayır vardır: Hasta olmanın/hasta hissetmenin faydaları' olmak üzere dört tema ortaya çıkmıştır. Bu temalar ve bulguların klinik doğurguları ilgili literatür ışığında tartışılmıştır.

Anahtar Kelimeler: Hipokondriya, Sağlık Kaygısı, Somatizasyon, Yorumlayıcı Fenomenolojik Analiz

To my parents and my beloved husband

ACKNOWLEDGMENTS

First of all, I would like to express my special thanks to my thesis supervisor Prof. Dr. Özlem Bozo Özen for her care, support, patience, guidance and encouragement not only throughout the dissertation process but also my graduate education. She provides me the opportunity to talk to her whenever I need. Also, she has always given me the opportunity to express my ideas openly. I have always felt very lucky to be one of her student. Thank her very much for the support that she gave me in my journey to be a clinical psychologist and a candidate academician.

Besides my advisor, I would like to thank the members of the thesis monitoring committee; Prof. Dr. Faruk Gençöz and Assist. Prof. Dr. Dilek Demirtepe Saygılı. Their valuable comments and suggestions helped me to look from different perspectives. I would also like to thank my thesis committee members; Prof. Dr. Bengi Öner Özkan, Assoc. Prof. Dr. Hatice Demirbaş, and Assist. Prof. Dr. Gaye Zeynep Çenesiz for their valuable inquiries and comments.

I am also grateful to Prof. Dr. Tülin Gençöz, Prof. Dr. Faruk Gençöz, M. D. Derya Gürsel who shaped me not only as a therapist but also as a person. I would also like to express my thanks to Doç. Dr. Deniz Canel Çınarbaş, Assist. Prof. Dr. Yağmur Ar Karcı, Assist. Prof. Dr. Gaye Zeynep Çenesiz, Assist. Prof. Dr. Ezgi Tuna, Dr. İncila Gürol Işık, Dr. Pınar Kaya, Dr. Derya Gürcan and Dr. İlknur Dilekler for their contributions to my development as a clinical psychologist. I learned many things about my weaknesses and strengths. Moreover, I can say that everyone I came across during my education at METU Clinical Psychology Program made a contribution to this learning process. Thank you all.

Also, I would like to thank you Assist. Prof. Dr. Sevda Sarı Demir. Thanks to the qualitative research course that she gave and our studies together, I learned many things about qualitative studies.

My sincere thanks also goes to Derya Özbek Şimşek. Anytime I had a difficulty related to my thesis, she encouraged me and made me believe in myself. Besides, I have always felt the support of Gökçen Bulut. Thank you very much for your help and always listening to me and trying to find a solution.

I would also like to thank my friends and collegues Elif Ünal, Tuğba Uyar Suiçmez, Begüm Şengül, Selin Temizel, Sinem Baltacı, Seray Akça and Fazilet Canbolat for their support they give me throughout my graduate education.

I am also very grateful to my special friends, Burcu Hızlı, Arzu Arslan, Zeynep Koçak, Raziye Demir Karataş, Alperen Karataş, Emre Evin, Duygu Akgün Evin, Esma Dilruba Karataş, Selin Uçar. They were always there for me when I needed a support.

My sincere thanks also go to my roommates and collegues at METU: Fulya Kırımer Aydınlı, Seren Güneş, Sanem Küçükkömürler, Şükran Okur, Sinem Baltacı, Buse Gönül and Ümran Yüce Selvi. I have always felt lucky to be working with you. You have always been there for me.

I also want to thank to my friends and collegues Huri Gül Bayram Gülaçtı, Zeynep Şaklar and Aylin Aras. You listened everything I said with genuine interest.

For their contributions to find my participants, I would like to thank to Assoc. Prof. Dr. Hatice Demirbaş, M. D. İnci Özgür İlhan, Tuğba Uyar Suiçmez, Aylin Özkan and Çisem Utku.

I would also like to thank The Scientific and Technological Research Council of Turkey (TÜBİTAK) for the financial support provided me throughout my undergraduate and graduate education.

Lastly, but most importantly, I would also like to express my deepest gratitude to my husband, Giray Bulut, and to my parents Adnan Gökdemir and Zeynep Gökdemir and my sister Canan Gökdemir Doğruyol who have given me unconditional support and endless love. I would not be the person I am today without them.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

GENERAL INTRODUCTION

Argan: Why will you not believe that a man can cure another?
Beralde: For the simple reason, brother, that the springs of our machines are mysteries about which men are as yet completely in the dark, and nature has put too thick a veil before our eyes for us to know anything about it.
Moliere, The Imaginary Invalid

The mind-body problem dates to old times and it remains in the scope of both philosophy and modern science. The nature of mental processes and their relations with the body are the main focus of the problem. Whether the mind and body are separate or different entities and if they are separate, how they come together, and whether there is any interaction between them; if they are not, then what the mind is, whether it is just a physical thing or something else are some fundamental questions at the center of the discussions (Bunge, 2014).

Psychology as a discipline must also deal with the mind-body problem. In the historical development of psychology, ideas about this problem changed and became varied. Initially, the dominant view was monistic and according to this view, the only entity is the body. Psychologists at that time took on the behaviorist approach that suggested all psychological processes can be reduced to observable behaviors and physiological events. However, the animal models remained incapable of explaining humans. Then, psychologists conversely started to give importance only to the mind: “Everything is in your mind.” That was a monistic approach as well. The followers did not deny the presence of physiological processes at all, but they thought that psychological processes including emotions, cognitions, and desire were determinants of behaviors and physiological processes. The third view accepted the dualism of mind and body, yet they accepted these two as autonomously coexisting entities functioning completely different from each other. In the fourth view, the interaction between mind and body was pointed out and instead of naming them as structures, “system” was preferred to emphasize their interaction. Lack of sleep or hunger, for instance, are some physical states diminishing creativity and concentration and this shows that the body has an effect on the mind. On the other hand, when an individual feels fear or anxiety, his/her heart rate increases, or he/she sweats more and these physical symptoms exemplify the influence of the mind on the body. The last view argued that mind and body constituted one unity but the attempts to

name this unity as “psychophysics” do not meet the needs of a comprehensive construct (Kreitler, 2018).

Although the interaction between mind and body has been accepted over time, in the contemporary classification systems, mental and physical disorders are still differentiated from each other. This kind of differentiation implies that physical illnesses have a different status from mental illnesses and the emphasis has been made on the presence of “real” illness (Kendell, 2001). At this point, hypochondria, becomes a challenge to that kind of classification, since it appears that individuals have physical complaints in the absence of “real” illness and it settles down at the center of the discussions about the psyche-soma relationship (Wintrebert, 2009).

1.1. The Concept of Hypochondriasis and Related Characteristics

The term “hypochondria” came from ancient Greeks; the student of Hippocrates, Diocles of Carystus. He named a real and painful disorder of the “hypochondrium”, the part of the “under the rib” - generally stomach-, as hypochondria (Berrios, 2001; Brown, 1936; Grinnell, 2010; Taylor, 2016; Wintrebert, 2009). Throughout the historical development of hypochondriasis as a term, its connotations have changed. In the 17th century, Sydenham used it for male hysteria as a counterpart of female hysteria and he described it as “the disturbance and inconsistency between mind and body” (Lipowski, 1988, p. 1358) as a result of modern life’s heightening of nerve-mediated sensibility (Risse, 2005). By the mid-17th century, hypochondriasis started to be used for causeless depression, sadness, and melancholy breaking the association between the body and the mind (Burgoyne, 2004). Then, it was perceived as a “popular disorder” suitable to the English way of life (Jana, Praharaj, & Mazumdar, 2012). In fact, at the end of the 18th century, hypochondriasis became a malady in British culture as people were wrapped up in well-being and having healthy body. This malady is a kind of challenge and threat to the medical culture and the well-being policy (Grinnell, 2010). In the 19th century, organic diseases, such as gastrointestinal diseases were removed from the category of hypochondriasis (Noyes, Stuart, Watson, & Langbehn, 2006). Later, in 1928, Gillespie defined hypochondriasis as the preoccupation with physical or mental disorder although there is no congruence between the believed illness/disorder and the actual problems, and this general definition still seems to protect its validity (as cited in Baur, 1989).

In the literature, even today this dynamic old concept does not refer to a particular meaning although the different meanings of hypochondria share some common characteristics such as an intense concentration on bodily sensations, belief of having a disease, and the variable

nature of complaints meaning that the complaint may change from one organ to the other easily (Katzenelbogen, 1942). Every theoretical approach attempts to explain the concept of hypochondriasis and its related qualities from its own perspective. Among these differing approaches, the cognitive-behavioral approach was the first to be chosen as a starting point. Then, the attachment theory approach, and the psychoanalytic approach were explained to provide a basis. The reason for choosing the cognitive-behavioral approach was that the researches are mainly conducted according to the perspective of this approach and the reason for choosing the attachment theory approach and the psychoanalytic theory approach was that they provide a detailed etymological perspective to hypochondria.

1.2. Hypochondriasis in DSM Perspective

The hypochondriasis as a diagnostic category has been a debated issue for a long time. The questions gathered around whether it is a clinical entity itself or a part of other heterogeneous psychopathologies (Katzenelbogen, 1942) and whether it is a mental state disorder or a personality construct (Hollifield, 2001). That means, professionals did not agree on its definition, independence, validity, and classification (Starcevic & Lipsitt, 2001). For example**,** Kraepelin took hypochondriasis as a part of various psychotic syndromes but not as a separate clinical matter (Katzenelbogen, 1942).

There is also a controversy in the psychiatry literature about in which category hypochondria should be included: Somatoform disorders or anxiety disorders (Scarella, Laferton, Ahern, Fallon, & Barsky, 2016). Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) classified hypochondriasis under somatoform disorders, which is a high-order category also including body dysmorphic disorder, pain disorder, somatization disorder, and undifferentiated somatoform disorder (American Psychiatric Association [APA], 1994). In addition to this nosological problem, the usefulness of somatoform disorders has been questioned, as well (Pagalilauan, 2014). DSM-IV also defined hypochondriacal personality disorder as a different category based on the differentiation of Axis I from Axis II disorders. The criteria for diagnosis as hypochondriasis and hypochondriacal personality disorder in the DSM, 4th Edition Text Revision (DSM-IV-TR) are shown in Table 1. However, as seen in this table, these two categories share too many common features leading to an epistemological problem. Furthermore, the differentiation between Axis I and Axis II disorders has been made by relying on the persistence of the symptoms and behavioral change, but this differentiation is problematic in itself, since there is no theoretical, phenomenological or psychobiological basis behind it. The high comorbidity between these two categories makes the construct validity questionable (Hollifield, 2001).

Table 1. *Diagnostic Criteria for the DSM-IV-TR Hypochondriasis (APA, 1994)*

Hypochondriasis	Hypochondriacal Personality Disorder
A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.	Excessive preoccupation with maintenance of health with associated behavior The perception of minor ailments and physical symptoms is distorted and magnified into major and life-threatening disorder
B. The preoccupation persists despite appropriate medical evaluation and reassurance.	The rigidity of beliefs about health and lifestyle ensures their persistence
C. The belief in Criterion A is not of delusional intensity and is not restricted to a circumscribed concern about the appearance	
D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Repeated recourse to consultation with medical and associated disciplines for reassurance, investigation, and treatment
E. The duration of the disturbance is at least 6 months	

This "hypochondriasis" diagnostic category was eliminated from DSM-V since it has an old and misleading etymology, and also has derogatory and stigmatizing connotations (Starcevic & Noyes, 2014). In DSM-V, the solution to the problem of categorization of hypochondriasis has been attempted by adding two diagnoses instead: Somatic symptom disorder to refer to people who have excessive bodily symptoms, and illness anxiety disorder for people who are excessively anxious about the illness without having any significant somatic symptoms (APA, 2013). The criteria for both were shown in Table 2. In spite of attempting to solve the problem of categorization, that type of differentiation has also been criticized by some scholars due to ambiguity in terms of both diagnosis and treatment (Brakoulias, 2014; Ghanizadeh & Firoozabadi, 2012). The division of hypochondriasis into two, according to the presence or absence of the somatic symptoms, for example, has been evaluated as arbitrary. Moreover, somatic symptom disorder was found heterogeneous even more than "hypochondriasis" (Starcevic & Noyes, 2014). Ghanizadeh and Firoozabadi (2012) in their article, discussed that the new diagnostic criteria do not say anything about how to differentiate a symptom as medical or psychological nor do they guarantee non-stigmatization of patients with somatic symptoms. They questioned how to decide on the diagnostic category in case the patient could not remember the directionality of symptoms, whether anxiety symptoms are before somatic symptoms or vice versa.

Table 2. *Diagnostic Criteria for DSM-V Illness Anxiety Disorder and Somatic Symptom Disorder (APA, 2013)*

Criteria	Illness Anxiety Disorder	Somatic Symptom Disorder
A	Preoccupation with having or acquiring a serious disease	One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B	Somatic symptoms are not present or, if present are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.	Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following: 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms. 2. Persistently high level of anxiety about health or symptoms. 3. Excessive time and energy devoted to these symptoms or health concerns.
C	There is a high level of anxiety about health and the individual is easily alarmed about heal status	Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)
D	The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) exhibits maladaptive avoidance (e.g., avoids doctor appointments or hospitals).	
E	Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over time.	
F	The illness-related preoccupation is not better explained by another mental disorder	

In addition to these problems, these new categories look unfamiliar to most of the clinicians, and they do not frequently use these categories. Thus, hypochondriasis and health anxiety are preferred in the literature instead. Despite not ever being an official diagnosis, health anxiety is frequently used for the affective part of hypochondriasis and related behaviors such as reassurance seeking. It is considered under the broader concept of "hypochondriasis", which additionally includes cognitive components. Moreover, hypochondriasis is usually understood as a severe form of health anxiety (Starcevic & Noyes, 2014).

After reflecting on all the complications with the term "hypochondriasis" in the psychiatry literature, an attempt was made to transmit some theoretical approaches differentiating with

the mainstream psychiatric approach to give a more in-depth perspective about the topic. Moreover, since the differentiation between hypochondria and somatization disorder is vague, and they show high comorbidity (Noyes, Stuart, Watson, & Langbehn, 2006), and there are studies showing the similarity of these two categories in terms of psychological variables such as depression, somatosensory amplification, and somatoform dissociation (Kırpınar, Deveci, Kılıç, & Zihni Çamur, 2015), the relevant literature about somatization has been addressed, as well.

1.3. Cognitive-Behavioral Approach to Hypochondriasis

According to the cognitive-behavioral approach, hypochondriac individuals constantly misinterpret harmless physical sensations as indications of physical illness, and this is the main characteristic of hypochondriasis. Anxiety of the person, who has negative images and thoughts that his/her health is under threat, increases and that anxiety triggers more physiological stimulation constituting a vicious circle. The patient could interpret the physicial arousal as an evidence of being ill, and following this, his/her focus on the body and preoccupation with health increase as well (Salkovskis & Warwick, 1986; Warwick, 1989). The feared illnesses vary but they are usually chronic illnesses such as cancer or multiple sclerosis (Warwick, 1989). Moreover, the cognive-behavioral formulation suggested that erroneous appraisal of health-related stimuli is related to both the individual's general beliefs about health and specific beliefs about the content of stimuli. To understand the origin of dysfunctional beliefs in individual's life, a close examination into the personal experience of illness including illness in close relatives was suggested (Warwick, 1989).

In the behaviorist perspective, the sick role may provide an advantage to the individual. To put it more explicitly, because of an illness, the patient can receive more attention and sympathy from loved ones and get help from them or be exempt from work responsibilities or some other responsibilities such as domestic chores. These kinds of advantages of the symptoms are called secondary gain, and according to behaviorists, this sick role continues due to learning processes based on behavioral contingencies: Reinforcement, and reward mechanisms (Craig, Drake, Mills, & Boardman, 1994; Sata & Munday, 2017). Pairing attention or other mentioned advantages with illnesses can rest upon experiencing similar patterns in childhood or witnessing ill parents in those years (Barsky & Klerman, 1983). Accordingly, the characteristics of hypochondriac individuals such as searching for a diagnosis rather than a treatment, giving a negative response to treatment, or establishing a conflictual and unsatisfactory relationship with doctors have been associated with their reluctance to quitting the sick role and its concomitants, but that does not mean they continuously or deliberately do

that. This approach emphasized the role of physicians and family members in the persistence of the somatic complaints as they both positively reinforce the independence of those individuals and negatively reinforce illness behaviors in addition to expressing somatic symptoms in a verbal way (Barsky & Klerman, 1983).

1.4. Attachment Theory Approach to Hypochondriasis

According to the attachment theory approach, the childhood experiences with parents (or caregivers) lead to a set of internalized representations of relationships and those representations persist into adulthood (Bowlby, 1969; see also Hazan & Shaver, 1987; Wearden, Perryman, & Ward, 2006). Based on Bowlby's arguments regarding the models of the self in relationships and others in relationships, Bartholomew and Horowitz (1991) made a description of four adult attachment styles: secure attachment, preoccupied attachment, avoidant-dismissing attachment, and avoidant-fearful attachment. In the secure attachment, individuals have a positive view both of themselves and others, perceive themselves as worthy of love and support and others as trustworthy and reliable. In the preoccupied attachment, individuals have a negative view of self, they feel worthless, and their self-esteem is low, yet they have a positive and idealized view towards others. This attachment style has been associated with inconsistent caregiving. Fear of loss and need for assurance have been the characteristics of this attachment style. In the avoidant-dismissing attachment style, individuals have a positive view about themselves, but they avoid close relationships to protect their sense of independence. In the avoidant-fearful attachment, they perceive themselves as unworthy but needy, and others as unreliable and rejecting leading to approach-avoidance style relationship with others.

Attachment theory tries to understand the role of interpersonal relations on how health-related behaviors are developed and proceeded (Maunder & Hunter, 2001). According to the theory, these abovementioned attachment styles have been activated, especially when there is a threat, including major life changes and adverse events such as illnesses (Bowlby, 1973). Stuart and Noyes (1999) linked bodily complaints and somatization with the anxious attachment style in childhood and said that when the child becomes ill repeatedly and the caregiver does not respond to the needs of the child, this may have a consequence on symptom experience and health behaviors in adulthood. That is, in adulthood, somatization could be used to evoke others to receive care indirectly from them as a part of restoring a sense of security. In adulthood, somatization could be used to take care indirectly. Attachment styles may also affect sensitivity to chronic pain and their characteristics. Dismissively attached hypochondriac patients, for instance, are more prone to perceive healthcare

professionals as unconcerned, so they tend to capitulate to the chronicity of their problems. Patients with preoccupied attachment styles, on the other hand, are expected to change their practitioners very frequently in expectation of relieving their pain, but that may strengthen abandonment beliefs since the possibility of rejection gets stronger with this pattern (Mikail, Henderson, & Tasca, 1994).

Individuals with hypochondriac symptoms are well-known with their attempts to get care and reassurance from health care professionals (Wearden, Perryman, & Ward, 2006). Hunter and Maunder (2001) argued that anxiously attached people, the preoccupied style in Bartholomew and Horowitz's (1991) categorization, were more likely not to believe their own ability to deal with illness and were also disposed to be in search of excessive care seeking and reassurance, but at the same time to be not satisfied by the reassurances that they receive.

Attachment theory makes some explanations on the characteristics of hypochondriac individuals, and followers of the theory conducted studies illustrating the relation between attachment styles and features of hypochondriac individuals such as between anxious attachment and high level of arousal towards physiological changes, or between avoidant attachment and physiological inhibition (Schmidt, Strauss, & Braehler, 2002). However, mechanisms of hypochondriac individuals remain unclear. Therefore, psychoanalytic theory should be examined, as well.

1.5. Psychoanalytic Approach to Hypochondriasis

As discussed in the previous sections, the categorization-based approach to hypochondriasis is not enough to explain all the characteristics of hypochondriac individuals and also to give a direction to the therapy process. Hence, to understand the underlying mechanisms and develop appropriate therapeutic interventions accordingly, the psychodynamic approach was examined (Lipsitt, 2001, p. 183). Hypochondriasis is a complex issue for psychoanalysts as well, which they encountered in various conditions such as neuroses, psychoses, hysteria, obsessional neurosis, and schizophrenia (Rosenfeld, 1958).

The psychoanalytic approach shows interest in examining the unconscious meaning of the symptoms as well as unconscious needs, wishes, and fantasies of the patients (Lipsitt, 2014). Specific to hypochondriasis, the psychoanalytic approach focuses on the fear of death in hypochondriac individuals, their firm adherence to the symptoms, their behavioral patterns in terms of seeking and rejecting help, and the usage of illness as a defense. Furthermore, the psychoanalytic approach pays attention to hypochondriac individuals' guilt, aggression and

hostility feelings, and their stimulation of negative emotions on physicians, as well (Lipsitt, 1974; 2014). For instance, the catastrophic condition accompanying illness was associated with relieving the hypochondriac individual's need for punishment, which is a consequence of unconscious guilt. The practical importance of this discovery, according to Freud, comes from this need being the ultimate obstacle in front of therapeutic work. Concerning neurosis, the subject is satisfied with the suffering and holds strictly to the illness (Wintrebert, 2009). Another example is that fear of death and aging seem an integral part of hypochondriasis and in the psychodynamic point of view, those symptoms have been explained as a defense against death fear (Noyes, 2005, p. 132).

Before Sigmund Freud, it is not possible to mention a psychoanalytic theory since he systematized the relation of unconscious to the mental mechanisms. He went beyond merely referring to the unconscious and offered an exploratory model of the mind (Lipsitt, 2014). He is an influential figure for the psychoanalytic approach and his ideas on somatization and hypochondriasis inspired many theoreticians following him. That is why there was an attempt to summarize his ideas at first.

Before explaining the opinions of Freud on hypochondriasis in detail, I tried to explain his and his followers' approach to the "body", because "body" has an important role in understanding hypochondriasis according to the psychoanalytic approach. The importance of it for psychoanalysis comes from Freud's encounter with hysteric patients' symptoms and their bodies during his studies with Charcot (Canellopoulos, 2010). Those studies were crucial in terms of indicating that biological reasons are not obligatory for physiological symptoms (Burgoyne, 2004). Freud linked the unconscious with the body, but the body, in his perspective, should not be taken into account as a biological one (Canellopoulos, 2010). According to him, the human subject has two bodies: a physiological and erotogenic body, and the latter one plays an essential role in hysteria (Chapman, 1999). The erotogenic body (or pleasure body) in Freud's terms is the imaginary one in Lacanian sense (Chapman, 1999). Furthermore, the subject's relation to his body is not a pre-given; in the beginning, there is no psychic representation of the body (Burgoyne, 2004). The mentioned body here is a constructed reality.

Lacan also conceptualized the body in a similar way to Freud: the body is not primary, on the contrary, the body is something constructed, that is to say secondary. All of these do not mean that there is no biological body, yet it means that human beings can access it only through the mediation of language (Gessert, 2004). Lacan makes a distinction between the living being (the organism) and the body and says that "The living being is not the body." Thus, in Lacanian

understanding of the body, the subject *is not* a body, but he *has* a body. The secrets of the body have not been clarified in spite of all the developments in medicine (Canellopoulos, 2010). The medical approach evaluates the symptomatic body as the biological body; nevertheless, it is the body incorporating the language order. Hence, somatic symptoms in a neurotic individual are based on his own “understanding” of the biological anatomy, not the biology itself (Gessert, 2004).

Regarding the constituents of the body, Lacan explained that the living organism, the image, and language compose the body correspondingly to the real, imaginary, and symbolic registers of the Borromean knot (Canellopoulos, 2010). When the baby is born, he is not able to differentiate the inside from the outside until he is around six months old; that is when he encounters a coherent, coordinated image (his image or the other’s image). The image originates from the visual gestalt as seen in the mirror, providing a unification and a feeling of separateness from others. The child identifies with this image, and this process operates through the agency of others around the child who named him like, “Look, it is you.” (Gessert, 2004). Thus, the body is also a spoken body, “parlêtre”, entangled in the network illusion of signifiers belonging to the Other’s language. The body is divided into a signifying part and a real part by language, so it seems foreign, *“unheimlich*," to the subject (Canellopoulos, 2010). The association between the body and unconscious is provided by drive. The instinct has been converted into a drive through language, and the nonplussed subject is obliged to invent a relation to the object. The primary “jouissance” was lost after the subject’s coming into the symbolic world; “prohibited to whoever speaks” as Lacan said (Lacan, 1977). The subject’s relationship to the lost object continued via the drive in the form of satisfaction and the subject started to fantasize due to this unbearable and irreversible loss.

Lacan expressed that both the body and unconscious are intimate parts of the subject; but for the subject itself, both of them are alienated and in the dark. That is, the subject does not know what is going on in his own body, and this obscurity added threat dimension to the situation since the jouissance coming from the body is experienced as an intrusion. Considering the positions of the subject and the body, the answer to the question of which one is enjoying is the latter one, that is the jouissance of the body. In Freud’s words, “the body sexualizes non-sexual processes.” For example, in the Dora case, the cough has a different character and goes beyond an organic phenomenon, and it is a sexual event giving a symbolic value to it, as well. In Lacan’s opinion, the Real of the body, is understood as an organism and as the drive (Verhaeghe, 2001), has a decisive role in the master signifiers affecting a neurosis. Why specific master signifiers determine the construction of neurosis instead of others is an important question here. Freud answered that those particular signifiers are in connection with

the fixated drives for that subject; a signifier was in line with his jouissance. Lacan contributed to this explanation by integrating speech into it. Signifiers are not univocal. On the contrary, they are equivocal. While someone is talking, the listener shows a tendency only to hear what he wants. This selection is controlled by jouissance. As a clinical implication, he suggested that because of the fixation of the drives by the body, these could not be changed by analysis. However, this is not the case for the subject's position towards the drive processes (Declercq, 2004).

The importance of language in Lacanian theory comes from its function of separating the child from the mother and of providing signifiers to the subject to get access to his body and attribute meaning to it (Burgoyne, 2004). For Lacan, the subject experiences anxiety due to not being able to separate: the origin of anxiety is not lack of something, on the contrary, it is "the lack of a lack." When a sudden bodily excitation appears causing lack of lack and the subject fails to make sense of it by means of the signifier, then he experiences anxiety, and his body turns into a mess (Strubbe & Vanheule, 2014). That means, if the symbolization (a function of language) is not sufficient for the child to separate him from mother, he has difficulty in symbolizing his body and bodily functions in a coherent and organized way. Without adequate symbolization, the body stays as an enigma and as a potential danger (Gessert, 2004). When the characteristics of hypochondriac individuals, such as preoccupation with the body and health, and the expectation of possible illness are considered, it can be said that they try to manage their foreign body remaining as a threat for them. The imagined, feared, or exaggerated illness could give him a set of signifiers that he organizes himself around, and he gets in contact with others (Butler-Rees, 2011). Illness gives the opportunity to speak about somatic complaints, to go to the various healthcare professionals or to take medical treatment. The importance of the illness stems from the attempt to be cured, not the cure itself. That is the reason why the efforts to recover from the patient generally results in no relief, and the patient continues to be in search of a doctor for remedy. Negative test results or even statements from doctors like "Physically, there is nothing wrong with you" may be disturbing for the individual, since he replaces the sense of fragmented body by exaggerated concerns related to health to feel coherence. In practice, this manifests itself in denying or acting with suspicion towards the reassurance of the doctors or test results. Being diagnosed with an illness, on the other hand, sometimes brings relief, in that suffering from it is better than the obscurity of the body: it provides an opportunity to construct a more coherent identity around as emphasized (Gessert, 2004). Even if diagnosis sometimes causes intolerable anxiety, the hypochondriac complaint is somehow a matter of "naming" independently of emergent feelings (Leader, 2004). Precisely for this reason, confronting the patient with the notion that his symptoms' nature is not physiological but psychological does not serve the purpose although

it was a suggested intervention by some people such as Lazare (as cited in Sata & Munday, 2017). Naming Real elements of the body should be the aim of psychotherapies (Strubbe & Vanheule, 2014).

To better understand the place of the body in Lacanian theory, the notions of “jouissance” and “castration” deserve to be elaborated. Jouissance, translated into enjoyment in English, represents unconsciously getting pain and pleasure at the same time, and it also has a sexual connotation (Swales, 2012). In the clinics, health care professionals usually confront hypochondriac individuals who complain about suffering from their symptom, but at the same time, it seems as if they do not want to get rid of it. This situation can be explained by getting jouissance from the symptom (Wintrebert, 2009). Castration, on the other hand, means that subject renounced some portion of the bodily jouissance to acknowledge the Law of Desire. In other words, to become a part of a society, he must give up the sense of omnipotence and relinquish some instinctual satisfaction; a kind of sacrifice as Freud also stated. However, there is no way to wipe bodily jouissance out and the remainder is called surplus jouissance. It stays in the body parts and gives the essence to hysterical symptoms (Evans, 2017). All symptoms in a way make a reference to the body of jouissance (Canellopoulos, 2010). On the other hand, there is no way to speak of a relationship between “body-to-body” jouissance, we just dream about being one, which is not possible. Hence, the remaining jouissance was only for one individual; there is no possibility to share it. For instance, headaches or pain cannot be shared by another person. The symptom is a solution to a problem: not a collective but a personal solution that should be examined instead of simply “getting rid of” (Canellopoulos, 2010).

The relationship between language and body was also addressed by Max Schur as infants have undifferentiated and undeveloped psychic and somatic elements, but as they grow up and their language develops, they produce more conscious and psychic reactions instead of reacting somatically. In the case of trauma and developmental failure, the ego cannot deal with emerging conflicts. There is a regression to the early pattern and emergence of psychosomatic illnesses, or “psychosomatic regression” as named by Schur (Lipsitt, 2015).
Freud gave a new point of view to the classical medical approach conceptualizing hypochondriasis as “a disease that appeared in the absence of any real organic disease.” (Stathopoulos, 2017, p. 361), and showed the parallelism between hypochondria and organic disease instead. In “On Narcissism: An Introduction”, Freud (1914/2014) wrote that “Hypochondria, like an organic disease, manifests itself in distressing and painful bodily sensations, and it has the same effect as organic disease on the distribution of libido.” Freud also said that the hypochondriacal organ is similar to the aroused genital organ. Both of them are in pain, and they are not diseased ordinarily, but they are in a state of change. Furthermore,

he pointed out the similarity between dreams and hypochondria: “In dreams, incipient physical disease is often detected earlier and more clearly than in waking life, and all the current bodily sensations assume gigantic proportions. This magnification is hypochondriacal in character” (Freud, 1915/1917, p. 223). By showing these similarities, Freud set the ground for relating hypochondriasis to sexuality and for questioning the protective nature of the investment to the bodily sensations from physical diseases (Stathopoulos, 2017).

Although Freud seems to contribute relatively less on the topic of hypochondriasis, his formulation of the concept of “somatic compliance” as “the conversion of the excitation into a somatic innervation” was the basis of understanding all somatization disorders described after him (Lipowski, 1988). Not directly pointing out hypochondriasis, in the book “The Ego and the Id” he stated that “the ego is first and foremost a body ego” and this statement could be an explanation behind the arousal of physical (somatic) responses by regression (Lipsitt, 2014). Freud considerably elaborated on hypochondriasis while working on Schreber, who was a paranoid person case. Hence, hypochondriasis, as mentioned by Freud, was mainly related to the bizarre bodily symptoms that appeared before the psychotic attack having a protective function (Rosenfeld, 1984). In fact, the togetherness of psychotic symptoms and hypochondria is not uncommon. He also contributed to the topic while working on narcissism. Between the years 1891 and 1914, Freud related hypochondria with narcissism (Stathopoulos, 2017) and considered hypochondriasis as a narcissistic state being firmly in relation with paranoia.

The paper titled “On the Right to Separate from Neurasthenia a Definite Symptom-complex as Anxiety Neurosis” was the first work of Freud in which he used hypochondriasis as a term and defined it as the anxiety concerning the body (Stathopoulos, 2017). In the first drive theory of Freud, he distinguished ego impulses and sexual impulses and made three classifications: actual neurosis including neurasthenia and anxiety neurosis; psychoneurosis including obsession, phobia, and hysteria; and psychoses including delusion and melancholy (Röder, Overbeck, & Müller, 1995). In this classification system, hypochondria was listed under actual neurosis -real neurosis- as a third pathology (Freud 1912/1958). Individual’s confrontation with mentally non-representable somatic excitation leads to “actual neurosis”, and differently from psychoneurosis, there is an organic basis for it (Strubbe & Vanheule, 2014). Moreover, the source of actual neurosis was related to a disturbance in sexual metabolism: the subject’s lack of sexual satisfaction (Freud, 1895a). Freud thought that the reason behind sexual dissatisfaction can be experiencing sexual trauma in early life, excessive masturbation or rejected sexual intercourse, named as “coitus interruptus” as well, but hypochondriacs believe that their problems originated from exogenous reasons, not from their sexual lives (Starcevic & Lipsitt, 2001). While relating actual neurosis with sexuality, he wrote: “The mechanism of

anxiety neurosis is to be looked for in a deflection of somatic sexual excitation from the psychical sphere, and in consequent abnormal employment of that excitation" (Freud, 1895a, p.108). According to him, there is an increased blood supply to the region which hypochondriac individual complains about because the erotogenic zone is displaced by the real organ and this is the organic basis behind hypochondriasis (Brown, 1936).

According to Freud, anxiety in hypochondriasis originated from the ego libido (Rosenfeld,1958; Christogiorgos et al., 2013). In his opinion, a hypochondriac person invests in bodily organs of libido by stepping back from external objects (eroticization of the organs of the body), that is narcissistic investment including pleasure and pain at the same time in a paradoxical way (Starcevic & Lipsitt, 2001, p. 187). The reluctance of those patients to part from their symptoms and also with the physicians' frustration feelings stemming from an attempt to emancipate patients from their suffering has associated with this contradictory position (Lipsitt, 2014). Freud also explains that the pleasure experienced by a hypochondriac individual is unconscious and at the conscious level, the subject experiences too much anxiety due to the excitation of a particular organ since there is a tension emerging from ego's effort to get libido under control (Chapman, 1999*).* In spite of the categorizing hypochondriasis as an "actual neurosis" and emphasizing its traumatic and somatic origins, Freud argued that he had difficulty in choosing a somatic etiology rather than psychogenic etiology (Richards, 1981). To illustrate, in 1898, Freud said that the reason behind hypochondriasis might be the turning of self-reproach because of experiencing sexual act in childhood as shame or hypochondriacal anxiety; to be afraid of physical injuries as a result of the action. Freud's uncertainty about the classification of hypochondriasis under somatic or psychogenic origin manifests itself in the sentence that he wrote in a letter to Ferenczi*:* "I always felt that the obscurity in the question of hypochondria to be a disgraceful gap in our work" (Jones, 1955, p. 453 as cited in Richards, 1981).

Regarding the discussions on "actual neuroses", Verhaeghe combined the "actual neuroses" idea of Freud with the Lacanian perspective and claimed that in psychotic structure, because the Other failed to modulate the drive tension of subject, hypochondriac symptoms emerged as reflecting the impossibility of representing physical drive arousal. He drew attention to the body disturbances at the beginning of psychosis such as schizophrenia and said that in "actual pathology" there are no signification or symbolization processes so there is "something" in the body that cannot be named (Redmond, 2014; Verhaeghe, 2008).

Ferenczi, known as one of the followers of Freud, tried to link hypochondriasis with psyche and soma, and he thought that mental processes are crucial for hypochondria and proposed

that psychotherapy can treat individuals with hypochondriasis. Like Freud, he discussed that in hypochondriasis there is a concentration of libido to the organ. The term, “pathoneurosis”, was used by him to explain that organic diseases have neurotic consequences. This term is not only for revealing how the psyche has an influence on soma but also to illustrate how the somatic presses the psyche to work (Chemouni, 2001). He was also the first person who associated hypochondria with anal erotism. In his book, “First Contributions to Psycho-Analysis”, Ferenczi (1994) wrote that:

> A whole series of analyses, by the way, has convinced me that in very many cases hypochondria is really a fermentation product of anal-erotism, a displacement of unsublimated coprophilic interests from their original objects on to other organs and products of the body with an alteration of the qualifying pleasure. The choice of the organ towards which the hypochondria is directed is determined by special factors (somatic disposition, pronounced erogenicity even in diseased organs, etc.) (p. 323).

Another contribution of Ferenczi is that hypochondriac individuals are known as their observation of themselves and Ferenczi named this situation as “autonarcissistic splitting”. In this splitting, the body is divided into as healthy and sick parts and maintaining sickness of the body is an attempt to protect the mental part, and it is a narcissistic defense. The libidinal concentration to the organ may lead to the hypochondriacal or hysterical superstructure, and the sexual structuring of the patient determines which one of the superstructures will be the consequence. Presenting the transition between hypochondriasis and hysteria was Ferenczi’s another contribution to hypochondriasis (Stathopoulos, 2017).

Both Freud and Ferenczi remarked the similarity between organic lesion or disease and hypochondriasis in terms of their effect on the transference of the libido to the organ. Trauma eases the transfer of the libido to an organ that had previously received narcissistic attention (Schilder, 2013, p.143). Freud expressed that individuals direct their unconscious intentions to the external objects or images that could be their own body (self-images) (Thomä & Kächele, 2012).

Similar to Freud and Ferenczi, Schilder thought that in hypochondriasis, there is an increase of the libido for specific parts of the body. The hypochondriac organ is genitalized, and narcissistic libido is transferred to the organ and hypochondriasis is a defense against excessive libidinization of the organ by striving to isolate it from the body-image. Due to the clinginess to the hypochondriac organ, these individuals have difficulty in removing that part from their body and therefore that organ continues to stay in the body as a foreign body (Schilder, 2013, p.141). Freud mentioned that in the narcissistic stage the body as a whole is

regarded as a genital. For Schilder, it is also possible to say that the hypochondriac organ acts as an independent body (Schilder, 2013). In addition to the individualistic domain, Schilder emphasized the interpersonal interaction as the origin of the subjective experience of one's body. He conceptualized body image as a social phenomenon and defined body image as a changeable thing according to the situation instead of perceiving it as stable. In this change, identification, apersonization, and projection are essential processes. There is a continual interaction between one's body image and the body image of the other's, and it is beyond aesthetic comparison (Thomä & Kächele, 2012). Unlike Freud, Schilder did not consider hypochondriasis as an "actual" neurosis and emphasized that by projection, mental conflicts are converted into physical conflicts, i.e., the body and body organs. Hence, for him, the hypochondriasis is related to the unconscious (Rosenfeld, 1958).

Using the viewpoint of Freud as a base, Melanie Klein tried to broaden the instinctual conflict model with an internal object relations viewpoint. Applying this perspective to the hypochondriasis, Klein argued that the internal object has been able to turn into an aggressive one by itself, and this leads to the feeling of being intimidated by the internal body. Also, the target of ambivalence was chosen as a body ego rather than the psychic ego, and this is in itself a defense. Thus, hypochondria can be conceptualized both as an increase in narcissistic libido and as a struggle against it. Furthermore, Klein made a comparison of hypochondriacal symptoms and distinguished paranoid symptoms from the depressive ones. In phantasy, if pain and other symptoms were results of the internal bad objects' attack against the ego, then this belongs to the paranoid sphere, but in addition to this, if the ego is identified with the good objects' suffering, then this is depressive (Klein, 1935). Henry Harper Hart, one of the followers of Klein, explained that hypochondriasis is physically expressing the disturbed narcissistic balance, and uncontrollable aggressive conflicts are responsible for that (Röder, Overbeck, & Müller, 1995). That is to say, the child's early stages of development and related aggressive impulses are central in the Kleinian approach for hypochondriasis. By taking into consideration the role of internal objects and unconscious fantasy in the establishment of the psyche, the early depressive position that is a developmental phase, in which there are intense hate and guilt towards the inner "parent" objects, were associated with hypochondriasis. Projective identification and splitting were two mechanisms used to prevent the ambivalence stemming from the dependence to the parents concurrently with experienced aggression and to keep the feelings of hate and guilt towards internal objects and the fear of expected revenge against himself under control (Klein, 1955 as cited in Röder, et al., 1995). In conclusion, according to Klein, complaining about the body or about fears linked to it is an attempt to hide aggression towards internal objects (Leader, 2004).

As stated previously, both Freud and Klein discussed the regression to the early narcissistic state in hypochondriasis. In the article titled as “Some Observations on the Psychopathology of Hypochondriacal States”, Herbert Rosenfeld (1958) stated that he agreed with Freud and Klein’s opinion that there is a regression to the early infantile narcissistic state. On the other hand, he did not hypothesize it as a pure regressive state since there is no one type of hypochondriasis. He discussed that hypochondriasis is not only a regressive state, but it should be differentiated according to their temporary or chronic characteristics. When early infantile paranoid anxieties are stimulated, temporal hypochondriac anxiety could appear, and this may be the reason for the increase of these kinds of anxieties in readjustment phases such as puberty or middle age. The nature of chronic hypochondriasis is different. It is associated with a poor prognosis and rather than regression, it was thought as a defense against the confusional state having a schizophrenic nature (Rosenfeld, 1958), that is the difficulty to perceive the difference “between the self and objects, good and bad objects, heterosexual and homosexual sexual impulses and depressive and paranoid anxieties” (p.121). Rosenfeld listed the characteristics of hypochondriasis: “The complicated identification with damaged internal objects, use of projective identification, oral envy, a confusion of self and object, and the hypochondriacal state as a defense against depressive and persecutory anxieties.” (Lipsitt, 1974, p. 133). To put it more explicitly, when the projection mechanism is not enough as a defense, there is nothing left to protect the ego to be exposed to persecution from within and this is the anxiety being a source of hypochondria (Gutwinski-Jeggle, 1997). Rosenfeld also explained that if the normal splitting between good and bad objects did not take place; as a trial of splitting, hypochondriacs project their confusional anxieties into external objects and they also reintroject them into their bodies and body organs. Thus, the ego succeeds in splitting the confusional state from the mental sphere. He relates the chronic form of hypochondria with psychoses as Freud did, but unlike Freud, he did not make a differentiation between neuroses and psychoses in a categorical way. Rosenfeld did not think that hypochondriasis is a problem in which psychic conflict turns into physical experiences despite relating hypochondriasis with psychosomatic illnesses. He argued that the separation between the physical and psychical spheres is not certain in hypochondriasis. His contribution to the hypochondriasis literature was his emphasis on the pathological internal relationships and the role of aggression (Röder, Overbeck, & Müller, 1995).

One of Rosenfeld’s supervisees, David Rosenfeld, said that the severity of the preoccupation with health and observing own organs with the thought that to be diseased vary from chronic hypochondria to transient hypochondriac states. This transient one is encountered frequently when there is a change, bodily growth or migrations (Rosenfeld, 2018). The difference between functioning with a neurotic body schema and with a primitive psychotic body schema

is that in the first one, individuals psychologically feel a protecting and wrapping skin while in the latter they feel a fluid body schema and they psychologically feel as if they do not have a skin. Both are mobile and flexible schemes in which one's body image conception could alternate between those. That is to say, someone whose body image is close to neurotic may shift into the primitive body scheme in case of a personal crisis. Thus, David Rosenfeld (1984) also argued that there is not a single form of hypochondriasis and also those different forms could switch between each other, and each one's fantasy about the body image was different.

Similar to Herbert Rosenfeld and David Rosenfeld's differentiation, reflecting the opinions of French medical viewpoint, two forms of hypochondriasis were defined in the French dictionary. These were "L'hypochondrie vésanique" and "L'hypochondrie simple, non-vésanique." Delusions, hallucinations are features of the first type, and in the second one, the individual continuously worries about his health, and he is disposed to exaggerate suffering from real pain or imaginary sufferings. Yet, the general mental functioning of the individual is unaffected. On the other hand, for some others such as Felix Brown, that kind of differentiation was useless since simple hypochondriasis has often been mixed with a hypochondriacal delusion. Katzenegelbogen (1942) said that there is a confusion regarding the usage of "hypochondriasis" and using this term for psychotic individuals' somatic complaints was the origin of the confusion between non-psychotic individuals' hypochondriacal complaints and psychotic delusions with somatic content. He suggested using "somatic" rather than "hypochondria" to prevent this confusion.

Another contribution to the hypochondriasis literature comes from Charles William Wahl. As Katzenelbogen, he attracted attention to how hypochondriasis is an uncertain diagnosis and how this diagnosis was used in a wide range including over preoccupation with health and delusions or somatic harm that may be indicative of psychosis. Wahl (1963), in his article, took the definition of hypochondriasis made by Laughlin, "an obsessive kind of preoccupation with physical symptoms or body processes which is often accompanied by the development of various, and often shifting, somatic complaints" as a base (p.9). He especially attracted attention to the characteristics of individuals with hypochondriac complaints. The transient and changeable nature of the symptoms, disproportionately excessive subjective annoyance, being over-demanding and at the same time being adhesive to the illness and not valuing the physicians' efforts were described as their characteristics. Psychological and physiological explanations contradictorily increase anxiety instead of diminishing it. Their reaction to medication is usually adverse and they seem to build a barrier in front of physicians, as it was nullifying the expended energy for them and this could be one of the explanations behind why this subject is mostly ignored both clinically and theoretically. Moreover, Wahl mentioned that

hypochondriacs give the impression to physicians that they get some pleasure from being sick, and also, they seem to get a perverse pleasure in hindering help. Those features could be an illustration of hysterical “belle indifference” to the symptoms.

Wahl not only describes the characteristics of hypochondriac individuals but also produces ideas about that what could be the unconscious motivation behind hypochondriac symptoms since it looks as if the individual needs the symptoms to solve a life problem. One of the unconscious functions of the hypochondriac symptoms was expressing hostility towards what the physician represents. This unconscious reason is out of reach of the individual’s conscious, but they can be studied by special techniques. Wahl argued alleviating unconscious guilt is another most common motivation behind maintaining hypochondriac symptoms. Since the child cannot distinguish between thinking and doing, he may feel guilty, or there could be other reasons to feel guilty such as making an erroneous inference that there is causality between events concurring together. Taking into account all of these, Wahl said that hypochondriac individuals’ dependencies on their symptoms did not aim to reject the doctor’s trials of help aggressively, but they showed reluctance to “feel good” because their symptoms were a solution to a problem. Wahl also argued that hypochondriasis could be a defense against the fear of death. This mechanism works in such a way that when the child feels intense aggressive death wishes towards a parental figure, he could not accept those kinds of feelings, and he assumed the same thing would happen for him. Although illnesses evoke the possibility of death, suffering from it paradoxically protects the child against death at least temporarily, that is its protective value. Moreover, according to Wahl, hypochondriac individuals have been raised where physical complaints and illnesses are much spoken out. Due to identification processes, the child identifies with the fragility of those figures. For a child, it is hard to unconsciously perceive himself stronger and more adequate than his parents. The illness gives an opportunity to the patient to feel “body”, feeling that he is a somebody, and to nurse himself in the absence of strong and adequate parents. The last factor Wahl explained is the secondary gain that the patient unconsciously benefits from, such as getting care and affection. To find the secondary gains in the patient's life, a close examination of his life is necessary (Wahl, 1963).

To sum up, considering the place of hypochondriasis in the psychoanalytic literature, it is possible to say that in the period from the publications of Freud and Ferenczi to World War II, hypochondriasis did not attract attention in the psychoanalytic theory. It was possibly because different metapsychological models were unconnected with each other, and if ever, it has not been addressed systematically (Röder, Overbeck, & Müller, 1995). From that day to this, it is hard to say that "hypochondriasis" was placed in the psychoanalytic literature as a "clear"

entity; there is still ambiguity about it. In the psychoanalytic dictionary of Laplanche and Pontails, for example, there is no definition of hypochondriasis (Zangrilli, 2001). Hypochondriasis shows comorbidity with other psychopathological conditions such as acute anxiety neurosis, neurasthenia or compulsion neuroses rather than appearing as an isolated neurosis and it is so common to encounter it in the initial stages of psychoses. Despite the explained different characteristics, hypochondriacs also argued that they typically share a predisposition to be a narcissist (self-centered) and to isolate themselves regardless of whether they are neurotic or psychotic. Because of bearing the stamps of both neurotic and psychotic structures, hypochondriasis is even considered as a transitional stage between hysteric and psychotic reactions (Fenichel, 2005, p. 240).

1.6. Qualitative Studies Related to Hypochondriasis

According to the results of the qualitative studies about hypochondriasis (or health anxiety), reassurance seeking emerged as an important feature. In the study about internet use and health anxiety done by Singh, Fox, and Brown (2016), for instance, intolerance for uncertainty was found as a crucial factor for health-related web search. By searching, those individuals felt a sense of control and reassurance. The reason why individuals use the Internet was explained as filtering the problems before going to the doctor, specializing in illnesses that help to “sell” them to the doctors, finding a justifying reason for visiting a doctor and reducing anxiety and uncertainty. However, short-lived reassurance in those individuals led to further research. Moreover, besides the stated positive sides, web searching had health anxiety maintaining characteristics since the Internet generally implies a dangerous situation. The study of Okita et al. (2016) examined the characteristics of reassurance seeking in Japan. According to the findings, health anxious individuals’ motivation behind reassurance seeking was to be certain about their health condition and to take emotional support from health care professionals. It was also found that these individuals trust the views of professionals rather than people around them. Moreover, when the uncertainty about the diagnosis was eliminated, either the appropriate was initiated or the individuals were assured that treatment was not required.

There are also dissertations investigating hypochondria with a qualitative methodology. Beckett (2009) in her thesis mainly focused on the patient-doctor relationship from the patient’s perspective. In this study, she found that most of the participants had negative ideas about the doctors and if the doctors could not make patients feel that they cared enough, patients considered these doctors as incompetent. According to the analyses of interviews, she also discussed that hypochondriac individuals accepted their excessiveness of health anxiety on the contrary to the opinion that these individuals have poor insight, they have

anxious/ambivalent attachment style, in their childhood, they were exposed to an environment in which a family member had an illness (mostly a chronic illness) or where they had such an experience, or they lose loved someone.

In another thesis, Papis (2015) examined emotional skills and interpersonal tendencies in hypochondriasis with a mixed-method research design. According to him, the emotional needs of hypochondriac individuals were not met. Also, the interaction of emotional isolation with the experience of anxiety could make the development in emotional and interpersonal fields worse. Hence, he advised therapists working with them to intervene in their emotional and interpersonal insufficiency by developing a therapeutic relationship based on trust.

As far as is known, it can be concluded that the number and the scope of qualitative studies on hypochondria are not sufficient. Thus, conducting studies on this subject could contribute to the field in terms of theory and practice.

1.7. The Aim of the Study

Since the researcher of the study is a clinical psychologist, she encountered various somatic complaints in her professional practice and was also able to observe them in her daily life due to the high prevalence of those kinds of symptoms in her family. Individuals with hypochondriac symptoms specifically got the researcher's attention with characteristics like their fixation to their bodily symptoms and their difficulties in being persuaded to not worry about their health. Moreover, the theoretical approach of the researcher is based on Lacanian psychoanalysis in which transference is an important concept. Hypochondriac individuals have been well known with their disposition to get reassurance from significant others and health care professionals and at the same time refusal of the reassurance that they take. Hence, the researcher thought that trying to understand the transference established with hypochondriac individuals might be helpful for psychotherapies in which the relationship between the patient and the therapist occupies a more vital position than all the techniques.

As explained in the previous sections, hypochondria is a complex issue in terms of definition and categorization as well as the mixed emotions that arise on both the sufferer and the observer such as grandiosity, resentment, irritation, and guilt (Comay, n.d.). The current study aimed to explore how individuals with high health anxiety have interactions with their bodies and their experiences regarding the believed illness (or the illness that they were diagnosed with) and anxiety about the illness. Furthermore, the way they establish a relationship with others, especially with physicians, other healthcare professionals, and with whom they try to

get assurance was tried to be understood. The focus of the study is not making a statistical generalization. On the contrary, in-depth understanding of those individuals' interpretation of their complaints, and their emotions, thoughts, how they are influenced by their symptoms, and the ways they express themselves are the interests of researchers.

CHAPTER 2

METHOD

2.1. Methodological Background

2.1.1. The Reason for Choosing Qualitative Research for Studying Hypochondriasis

The difference between qualitative and quantitative research is related to the questions that are tried to be answered. In qualitative studies, describing a phenomenon in various cases and understanding how and why it changes are the foci while in quantitative ones, the focus is the amount. To put it differently, the purpose of the qualitative studies is to contribute to the development of concepts that clarify social phenomena by emphasizing how participants give meaning, perceive and experience those phenomena (Pope & Mays, 1995).

Hypochondriasis, is sometimes referred to as health anxiety in the literature as explained in the previous section, is an interdisciplinary subject being within mental and physical health professionals' area of interest. For the clinicians and physicians working with individuals having hypochondriac symptoms, making a careful assessment of their history and the course of symptoms, and giving attention to their interaction style, their language usage while describing their symptoms, and how they relate to their bodies were suggested (Lipsitt, 2015). To contribute to the practical applications, researches ought to cover these domains, and qualitative studies fit this purpose.

Health care deals with a human subject who is more complicated than the issues studied in the natural sciences. Thus, a research about mental or physical health should take the interaction of patients with physicians, changing roles of health-care workers and the organization of health services into account (Pope & Mays, 1995). Through a qualitative research method, hypochondriac individuals' feelings, perceptions, or actions regarding their somatic complaints, and the way that they get in interaction with health care professionals can be understood. Trying to understand the reasons and mechanisms behind a particular behavior does also increases the possibility of developing effective policies. Moreover, the person-centered nature of a qualitative research enables the researchers to approach participants of the study as human beings (Holloway, 2005).

2.1.2. Interpretative Phenomenological Analysis as a Methodology of Qualitative Investigation

Interpretative phenomenological analysis (IPA), which was developed by Jonathan Smith, has been used to explore the subjective experiences (Smith, Harré, & Van Langenhove, 1995). "Interpretative phenomenological analysis (IPA) has theoretical roots in phenomenology, hermeneutics, and idiography" (Smith, 2011, p. 9.). The philosophical work of Husserl constitutes the base of phenomenology. According to him, to understand a phenomenon, a rich description of the subjective experience is necessary.

Another phenomenologist Martin Heidegger also dealt with the subjective experiences, but he gave importance to the interpretation instead of description (Dowling, 2007). Based on the Heidegger's hermeneutic phenomenology, in IPA, engagement to those experiences and an interpretation of them by the researcher are necessary processes to access them (Smith & Osborn, 2003; Smith, 2011; Biggerstaff & Thompson, 2008). In other words, the reality is interpreted and shaped by the subject's experience and perception and by the interaction between the subject and the researcher. Also, the researcher explains the subject's personal experiences based on her/his conceptions that were expressed verbally, which is the interpretative part of IPA (Smith & Eatough, 2007). The researcher interprets how the participant gives meaning to his/her own experience, and this makes IPA double hermeneutic (Smith, Flowers, & Larkin, 2009). Therefore, the epistemology of interpretative phenomenological analysis emphasizes that it is not possible to directly or totally understand an individual's world, but it can be reached through the researcher's interpretations (Smith & Eatough, 2007). Since IPA focuses on how an individual gives meaning to her/his experiences (Willig, 2001), it offers a systematic approach to study the subjective experiences of a participant by making a very detailed examination of a case (which is the idiographic focus) (Smith, Harre, & Van Langenhove, 1995).

For the topics related to health, IPA is a frequently used method (Cronin & Lowes, 2016), since it allows healthcare professionals to see illness (a psychological condition having a physiological dimension in this study) from the eyes of the patient (Biggerstaff & Thompson, 2008).

2.2. Participants and Sampling Method

The age range and residential addresses of participants were restricted to ensure homogeneity that is necessary for including only the individuals who are qualified for the purposive sampling of IPA (Smith & Osborn, 2003). Therefore, only the adults (18-65 years old) and living in Ankara were recruited. The age range of the participants was relatively wide. There were two reasons for this. The first one was that the health anxiety of the participants whose ages over 40 at the time of interviews started earlier than this age. Secondly, in a study involving participants over the age of 65, no association was found between the increase in hypochondriac symptoms and age; thus, it was concluded that hypochondria is independent of age (Barsky, Frank, Cleary, Wyshak, & Klerman, 1991).

For this study, it was aimed to do the interviews with individuals who were experiencing hypochondriac symptoms and a high level of health anxiety. The Turkish version of the Health Anxiety Inventory (SHAI-18) was used to determine the potential participants with high health anxiety. The cut-off point on this inventory to include individuals to the present study was determined as 37.9. This value was found by Salkovskis, Rimes, Warwick, and Clark (2002) as the typical mean scores for high health anxiety in their study, and also, this score was suggested to capture hypochondriac patients (Sulkowski, Mariaskin, & Storch, 2011). Since there was no cut-off point suggested by the Turkish adaptation study of the scale (Aydemir, Kırpınar, Satı, Uykur, & Cengisiz, 2013), that value was used. Moreover, the question, "How much do you think that you are anxious about your health?" was added to the demographic information form, and via this question, the potential participants were asked to evaluate their health anxiety on a 5-point Likert scale with the following response options: (a) I am quite anxious b) I am a little anxious c) I am not sure d) I am not anxious e) I am not anxious at all). By doing this, it was ensured that the participants also accept their health anxiety. At the end of this process, the fourteen participants between 19-55 years old ($mean_{age}$ = 29.43), who were living in Ankara, and whose questionnaire scores were above 37.9 and who stated that they have anxiety about their health were included in the study.

Before interviewing the participants of the study, a pilot study was conducted to practice interviewing skills, to test and improve the established questions, and if necessary, to add more questions. The participant of the pilot study was a married, 30-year-old woman. The researcher had a prior acquaintance with the person. Although the researcher knew her as a person with high health concerns; she still administered the Turkish version of the Health Anxiety Inventory (SHAI-18) to her to objectively measure her health anxiety level and then she performed the interview with her. The participant's score on SHAI-18 was 43, indicating

high health anxiety. After the transcript of the pilot study was analysed, several points came into prominence. First of all, she attributed her illnesses to various factors including stress, her unhealthy lifestyle habits such as unhealthy nutrition, and her family background (her father was cardiac patient). She also emphasized that she felt angry when she felt sick and did not know the reason for it. In parallel with this situation, she felt relaxed when her treatment was clear, and the problem was completely solved by medical intervention. She stated that she perceived illness as torture and punishment. She also linked illness to death; she believed that when she got old, she would die due to an illness although she did not have any current death anxiety.

Her coping mechanisms with problems were either emotional suppression, emotional outbursts, or social withdrawal. When she was asked about her support sources, she said that she explained her problems to the individuals in the inner circle. Moreover, she was expecting help from physicians. She told that the physicians should provide good communication, be trustworthy, informative about the illness, good-humoured, and experienced, and finally, they should not be neglectful. When there was an uncertainty, she preferred male physicians. About certainty, she also said that if there is no absolute remedy, her adherence to the lifestyle changes that require long-term commitment decreases.

At the beginning of the interview, when she was asked questions about her relationships, she had difficulty in speaking, and then it was noticed that she was more comfortable talking about health issues. Another remarkable point was her career choice. She worked as a photographer but since she preferred birth photography, she worked mainly in the hospital environment. Beginning with this interview, participants were asked more detailed questions about how they made their career choices, in addition to the question about their occupation or which department they studied if they were a student. Besides, even if not included as a question in this study, it was decided to pay attention to whether the participants associate the illnesses to death and, if so, how they express it.

To find the suitable participants of the main study, the researcher applied to Ayna Clinical Psychology Unit at Middle East Technical University (METU), to the Department of Psychiatry at Gazi University Hospital, and the Department of Psychiatry at Ankara University School of Medicine, and got the necessary permissions from there. In addition to these, she asked METU Psychology Department freshmen if they know individuals suitable to the study, and finally, she announced the study on a popular Facebook group. In total, 44 potential participants filled out the demographic information form and the Short Health Anxiety Inventory (SHAI-18). Of these individuals, only 16 met the inclusion criteria, but two of them withdrew

from participation. One of them stated that she became worried about speaking and cancelled the appointment; and the other potential participant did not even make an appointment. Thus, 14 individuals accepted to be interviewed. While two of the participants were drawn from Gazi Hospital, and one of them from Ayna Clinical Psychology Unit; the remaining participants were recruited through announcements made in the classroom and on the Internet. In Table 3, detailed demographic information about the participants of the study was given. Instead of providing names of the participants, they were given nicknames to ensure anonymity.

The sample size in IPA depends on several principles rather than a certain rule. The depth and richness of cases, the purpose of the researcher, whether the researcher wants to compare or contrast cases, and pragmatic conditions such as rareness of the sample characteristics are important for determining the sample size (Pietkiewicz & Smith, 2014). While determining the sample size of the present research, the purpose of the study and how rich the information obtained from the interviews about the phenomenon were taken into consideration. IPA does not require big sample sizes; on the contrary, because of in-depth analyses of cases, small sample sizes are preferred (Smith & Osborn, 2003). Although there is no exact number for the size of sample, the suggested sample size for phenomenology studies is between 5 and 25 for Creswell (1998, p. 64, as cited in Mason, 2010) and at least 6 for Morse (1994, p.225, as cited in Mason, 2010). Therefore, the sample size of the current study was suitable for IPA.

2.3. Materials

2.3.1. Demographic Information Form

In the demographic information form, there were questions about the age, marital status, education level, working status, place of residence, perceived income, the physical and psychological health status of the participants, and if any, the type of treatment they were receiving. Also, the participants were asked to report if they thought they had a physical or a psychological disorder, even if they had not received an official diagnosis from a health-care professional. Moreover, to measure participants' perceived anxiety about their health, a question about how much they think that they are anxious about their health was added into the form.

Table 3. *Demographic Characteristics of the Participants*

Participant Name	Age	Marital Status	Education	Department of Education, Occupation or Job	Current complaints	Event/s associated with the onset of anxiety
Ali	44	Married (having 2 children)	Associate degree	Health technician (Works in the operating room)	Panic attack (diagnosed) Excessive asthenia, headache, stomach-ache	Stomach bleeding (at age 27)
Gizem	19	Single	Undergraduate student	Faculty of arts and sciences	Anxiety disorder (diagnosed) Fear of cancer (breast and lymph), diseases that can infect him from the outside, insect bites, diseases that will cause disability or deformation, cysts in the ovaries	Aunt's husband died from lung cancer (when she was at 8th grade) Her mother's surgery due to a cyst exploded in her ovaries and her parents' move to another city due to her father's job change
Melek	55	Married (having 2 children)	Primary school graduate	Nursing someone with Alzheimer's disease	Varicose veins, restless leg syndrome, migraine, hernia in the waist and neck, muscle tears in the shoulder, arthritis of the knee joint (diagnosed) Unaccountable headache and dizziness, and panic attack	In 2000, problems with her husband and the start of dizziness
Onur	20	Single	Undergraduate student	Faculty of arts and sciences	Abnormalities in the number of neutropenia in his blood value	Physicians suspicion that he has a serious illness due to an abnormality in neutropenia (when he was 11th grade)
Fadime	45	Married (having 2 children)	Primary school graduate	Housewife (but helping her husband who was hawker)	Anxiety disorder (diagnosed), Panic attack, the wound on her leg that she thought it is cancerous, tingling in her hands	Five years ago, a physician said to her that the pimple on her leg should be removed in a big hospital. Also, after the removal, she could not get a straight answer from physicians in terms of whether there is a risk of cancer or not.
Beren	20	Single	Undergraduate student	Faculty of management	Generalized anxiety disorder, post-herpetic neuralgia (diagnosed) Panic attack	Being diagnosed as genital herpes (one year ago)

Table 3 (Cont'd). *Demographic Characteristics of the Participants*

Participant Name	Age	Marital Status	Education	Department of Education, Occupation or Job	Current complaints	Event/s associated with the onset of anxiety
Demet	29	Single	Bachelor's degree	Teacher of mentally handicapped	Throat ache (thought that she has throat cancer)	Facial paralysis in 2008
Sevil	21	Single	Undergraduate student	Faculty of arts and science	Anxiety disorder, obsessive-compulsive disorder, depression (diagnosed) Fear to be cancer and losing individuals close to her	Death of her cousin (for death anxiety) Recurrent cancer of her aunt (for health anxiety)
Ada	21	Single	Undergraduate student	Faculty of management	Anxiety disorder (diagnosed) Fear of cancer	No specific event
Öykü	28	Single	Graduate student	Faculty of architecture	Hip fracture, femoroacetabular impingement syndrome, varicose veins, kidney gravel, hyperlaxity, Morton's neuroma, uterine fibroids	Health problems after a traffic accident
Melis	27	Single	Ph.D. Student	Research Assistant	Panic	Misdiagnosed malignant melanoma in 2015
Duru	28	Single	Ph.D. Student	Research Assistant	Illness anxiety disorder, various infections (diagnosed) Panic attack	Minor health problems but "traumatic experiences" such as entering the operating room without sedation
İrem	31	Married	Graduate	Instructor	The health obsession, Anxiety Disorder (diagnosed) Fear of cancer, panic, worries about persistent pain, chronic wounds, or about menstrual irregularities	Expelling kidney stones and cyst found in her breast
Kübra	22	Single	Undergraduate Student	Medical Faculty	Anxiety disorder (diagnosed) Thinking that having a bulk in her spinal cord, fear of cancer	Her mother's difficult pregnancy and the postpartum period, her brother's falling out of bed while she was cradling him

2.3.2. Short Health Anxiety Inventory

Short Health Anxiety Inventory (SHAI), which was developed by Salkovskis, Rimes, Warwick, and Clark (2002), consists of 18 items related to worry about health, awareness of bodily sensations or changes and feared consequences of having an illness. For each item, participants are asked to select one of the four statements reflecting their feelings best for the past six months. This instrument assesses health anxiety regardless of the condition of physical health (Abramowitz, Deacon, & Valentiner, 2007). A 4-point Likert type scale is used for scoring responses: 0 indicates no symptoms, 1 indicates mild symptoms, 2 indicates severe symptoms, and 3 indicates very severe symptoms (that is a clinical form of hypochondriasis). When a participant chooses more than one statement, the higher one is used for analysis (Kocjan, 2016). According to studies, the internal consistency reliability of the 18-item SHAI ranges between .74 and .96, indicating good to excellent reliability (Alberts, Hadjistavropoulos, Jones, & Sharpe, 2013). The correlation between the SHAI and health anxiety measure was statistically stronger than the correlation of the inventory with the other measures like anxiety and worry, depression, or social anxiety; thus, SHAI had convergent validity. Moreover, since the correlation between the SHAI and medical status was weaker than the correlations of SHAI with measures of anxiety vulnerability, anxiety and worry, and depression, divergent validity of it was supported (Alberts, Hadjistavropoulos, Jones, & Sharpe, 2013). The inventory was adapted to Turkish by Aydemir, Kırpınar, Satı, Uykur, and Cengisiz (2013). The Cronbach's alpha coefficient for the Turkish version of the scale was .91, which indicated a good reliability. Also, the correlation of the Turkish SHAI with other related scales such as the Hamilton Depression Scale evaluating hypochondriasis, varied between moderate to high values, which illustrated the validity of the adapted inventory (Aydemir et al., 2013). The Cronbach's alpha coefficient for the current study was .69 and it was very close to the acceptable value, which is .70 (Cortina, 1993). The sample size was smaller than the suggested minimum small sample size required to test Cronbach's alpha (Yurdagül, 2008; Conroy, 2015) and it may be the reason why the obtained value did not indicate good reliability.

2.4. Procedure

The ethical approval was received from the Human Subjects Ethics Committee of the Middle East Technical University (see Appendix A). The informed consent form (see Appendix B) to inform the participants about the study and to ensure confidentiality, the demographic information form (see Appendix C), and the Turkish version of the Health Anxiety Inventory (see Appendix D) were sent via an e-mail to the most of the potential participants. Due to practical reasons, three participants were given the hard copy of the questionnaire sets.

After the data were collected from the potential participants, the participants who were going to be interviewed were determined. The data of the study were collected via face to face semi-structured interviews (see Appendix E for the interview questions). Bearing the interview questions in mind, the researcher tried to be open to emerging topics and provided a comfortable environment to the participants where they can speak freely. Each person was interviewed only once, and the place of the interview changed depending on the convenience of the participant. To state more clearly, student participants and one participant who was not working came to the Middle East Technical University, where the researcher was studying. The other participants, who were working, were interviewed in their workplace. Participants were informed that they could leave the study whenever they want to do so. The interviews were tape-recorded, and participants were pre-informed about that procedure in the informed consent form. The interviews lasted between 50 minutes and 2 hours, with an average of 75 minutes. At the end of the interviews, the participants who were not getting professional help were told if they ask for a referral to a specialist. Those who asked for a referral were informed about AYNA Clinical Psychology Unit of Psychology Department at METU.

2.5. Data Analysis

Analyses were done according to the principles of IPA (Smith & Osborn, 2003). IPA's philosophy is based on phenomenology and ideography (Smith, Flowers, & Larkin, 2009); so, the detailed examination of each case and analyzing them separately before working up to more general categorization were required. Initially, the audio records of the first interview was transcribed. This transcript was read several times to capture a holistic idea about the participant and while doing this, some notes including the comments and thoughts of the researcher were taken on the left margin of the transcripts. Then, the initial notes were transformed into the emergent themes and these themes were written on the right margin. As a next step, the connections of the themes were examined, and the related ones were clustered to attain subordinate and superordinate themes. After constituting subordinate and superordinate themes for the first case, the same procedure was repeated for each case. As a result of cross-case comparisons, four superordinate themes emerged. '*Causal attributions of health anxiety: loss at the core as an unsettled matter*', '*Being drawn into the vortex of the symptom'*, '*An endless call to an expert for naming own experiences and eliminating uncertainty'*, and *'Every cloud has a silver lining: Benefits of being/feeling ill' were the final themes*.

2.6. Trustworthiness of the Study and Reflexivity

The quality of research has been indicated by expressions such as reliability and validity in quantitative studies, whereas in the qualitative studies, this is often referred to as “trustworthiness”. Although there is a controversy about the constituents of trustworthiness, there are some strategies accepted by many qualitative researchers to increase the trustworthiness of the study (Connelly, 2016).

Bracketing is an important part of qualitative researches which suggests the researcher to put aside his/her existing beliefs, values, knowledge, and experiences to increase the credibility of qualitative research. However, the Interpretative Phenomenological Analysis approach emphasizes the researcher’s evaluation of the participants’ interpretation, so the researcher’s preunderstanding has already been acknowledged. As a result, the perspective of the researcher could not be totally bracketed (Koch, 1995). Moreover, being entirely objective is not possible in qualitative researches (Crotty, 1996, as cited in Chan, Fung, & Chien, 2013), because the perspective of the researcher unconsciously hinders his/her approach to the research topic (Parahoo, 2006). Nonetheless, there are some strategies to strengthen the trustworthiness of the study. First of all, researchers should be aware of their own perspective, because it may influence the whole research process. The researcher’s explanation about the potential bias is called “reflexivity”. In this regard, I explained my theoretical approach and personal experiences about the subject of this dissertation.

I am a 30-year-old woman and I am studying for a Ph.D. in clinical psychology area. As a part of my education, I conduct psychotherapy, as well. I have been studying on Lacanian Psychoanalysis for three and a half years. Thus, my point of view towards psychological notions and psychopathology is influenced by Lacanian approach. In Lacanian theory, “real” is defined as ungraspable and impossible; so each subject has its reality that is different from the real (Evans, 1996). For this reason, this approach seems suitable to the underlying rationale of qualitative analysis which deals with the way the participants give meaning to the phenomena, and the way they perceive and experience them. Therefore, qualitative research orientation matches with my clinical orientation.

Moreover, unlike a psychiatric point of view, Lacan did not make a classification like normal and pathological; on the contrary, he emphasized the continuum between them, and the complexity of subjects (Romanowicz & Moncayo, 2014). Instead of many diagnostic categories, Lacan identified three main distinctive clinical structures; neurosis, perversion, and psychosis indicating the position of the subject in relation to Other and lack (Feher-Gurewich,

2003). All the other remaining categories can be evaluated as symptoms rather than separate categories, although the nature of symptoms changes in the structure they appeared. Considering the difficulty of placing the individuals with hypochondriac complaints into one category due to the lack of clear cut direction, this approach seems meaningful. All in all, I can summarize my approach to hypochondriasis as such that I did not focus on the diagnosis of participants but I thought that it is a symptom that can be discussed within a more general structure. Therefore, in the participant selection process, the diagnosis was not my primary concern; I selected the individuals with high health anxiety and also who were claiming that they are highly anxious about their health status.

Besides my theoretical standpoint, individuals with health anxiety are an important part of life. My mother is an anxious individual about her health. Despite not as worried as my mother, my sister is also preoccupied with health issues. For this reason, in the interviews, sometimes I felt that I was interviewing my family members, and from time to time, I noticed that I put myself in shoes of their children or other family members. Due to the possible reflection of my feelings, such as sadness and anger, into the research process, being familiar with the research subject might be disadvantageous. But, on the other hand, having a personal interest, taking notes about my feelings and their reflection on the research (called “reflexive diary”), and considering those notes both in conducting interviews and their analyses could be advantages of being an insider.

During the interviews, I also noticed that I experienced more health problems than I normally do. For example, I had to postpone the appointment with a participant to the next week due to temporary hoarseness. Also, in another interview, I had to take a short break due to a coughing fit. I thought that while being in interaction with someone who has complaints related to health, I might be similarly developing somatic complaints to cope with the feelings that awaken in me.

In addition to being aware of the possible effects of personal standpoint on the research process, collecting data through semi-structured face-to-face interviews was another suggested strategy to increase the credibility of the research (Chan, Fung, & Chien, 2013). The semi-structured nature of interviews requires the researcher to listen to the participants in a focused manner and to enable them to talk about the topics that he/she brings, without being limited to the pre-prepared questions. Also, as suggested by Chan and her colleagues, throughout the process of the data collection and evaluation of interviews, I stayed back from doing a literature review to protect my curiosity and to be open-minded.

Furthermore, in the process of constituting the themes, the initial evaluations made on the transcripts of the participants were discussed with the thesis advisor and then the emergent themes with their direct quotations were discussed with a research team to make the research process transparent. This team consists of the researcher and two Ph.D. candidates in clinical psychology who were conducting qualitative studies, as well. Also, the thesis monitoring committee followed the research process beginning from specifying the topic of the research to the constitution of the themes. Hence, discussions in those meetings were taken into consideration during the data collection and analysis process.

CHAPTER 3

RESULTS

As a result of the interpretative phenomenological analysis of 14 cases, four superordinate themes emerged: the first theme was '*Causal attributions of health anxiety: loss at the core as an unfinished business*', the second theme was '*Being drawn into the vortex of symptom'*, the third theme was '*An endless call to an expert for naming own experiences and eliminating uncertainty'*, and the fourth theme was '*Every cloud has a silver lining: Benefits of being/feeling ill'*.

Table 4. *Superordinate and Subordinate Themes Emerged as a Result of Interpretative Phenomenological Analysis*

1.	**Causal attributions of health anxiety: Loss at the core as an unfinished business**
1.1.	Loss related anxiety "running in the family"
1.2.	Being already anxious about the loss
1.3.	Experiencing/observing/anticipation of a loss
2.	**Being drawn into the vortex of the symptom**
2.1.	Health-related career choice
2.2.	Preoccupation with precautionary behaviours
2.3.	A priori thinking
3.	**An endless call to an expert for naming own experiences and eliminating uncertainty**
4.	**Every cloud has a silver lining: Benefits of being/feeling ill**
4.1.	Receiving attention and care
4.2.	Health anxiety itself a coping mechanism with other life difficulties
4.3.	Rearrangement of priorities and relief from responsibilities: My health above all else

3.2.1. Causal Attributions of Health Anxiety: Loss at the Core as an Unfinished Business

All participants were asked when and how their health concerns began and under which conditions these complaints increased to understand which factors contributed to the onset of health anxiety.

Having an anxious parental figure was stated by participants as one of the contributing factors to their health anxiety. The parents and sometimes the grandparents were described as anxious in general or specifically anxious about health issues. The emphasis on the transmission of anxiety from one generation to the other was sometimes too strong as if there was almost a "genetic heritage" of anxiety. For example, Kübra said:

> (...) How should I say this my uncles, my uncle has it too. For example, one of my uncles doesn't have such a thing but we use the same medicine. For example, he also uses Paxera, he also has some obsessive things like this. None of ours is like a disorder I mean, how should I say it, not to the extent that it greatly affects our daily lives, but there are many in our family who use it. I wonder if we have a genetic inclination as well because my grandmother also uses it. They (physicians) gave it so that she could relax because she was very tense.
>
> *(…) Nasıl desem ya dayılarım dayımda da var mesela bir dayımda da böyle bir şey yok ama onda da onunla aynı ilacı kullanıyoruz. Mesela o da Paxera kullanıyor ben de onun da bazı böyle obsesif şeyi var. Ya hiç birimizinki böyle hastalık yani nasıl desem günlük hayatımızı etki aşırı etkileyecek boyutta değil ama ailemizde çok kullanan var acaba diyorum genetik bir yatkınlığımız da mı var çünkü anneannem de kullanıyor o da çok gergin olduğu için rahatlaması için verdiler.*

This transmission from one generation to another was considered to be essentially the transmission of anxiety about loss that seems to be unresolved. Duru mentioned her parents' anxiety and said that her sister did also show a similar pattern. As seen in her statements below, her father's and her mother's anxiety started after the loss of their mothers. Thus, she attributed the beginning of her parents' health anxieties to their experiences of loss.

> (...) I lost both my grandmothers to cancer, and recently my aunt's husband also died of cancer. I never saw my grandmothers, but I think there is a familial transfer because my father suffers from panic attacks and my mother is likewise anxious about illnesses. They have similar anxieties. Both my mother's mother and my father's mother, I mean both their mothers died around the same time. One died of breast cancer and the other of uterine cancer and my parents were with them when this happened. They witnessed the whole thing including the final moment. My father's panic attack began when he lost his mother, and my mother's panic attack began when she lost her mother. My sister has some minor problems such as these. From what I can gather on my own, I suspect familial transfer as well because as my age advances, as a reach 30, I also began to display uncontrollable and similar panic attacks and anxiety disorders.
>
> *(…) Anneannemi ve babaannemi kanserden kaybettim, yakın zamanda eniştemi de kanserden kaybettim. Anneannemi ve babaannemi hiç görmedim yani ama sanırım aile aktarımı var çünkü benim babam panik atak hastası annemde de aynı şekilde hastalık kaygıları var. Benzer hastalık kaygıları var. Annemin de babamın da annesi yani ikisinin de annesi aynı zamanlarda aşağı*

yukarı vefat ettiler. Birisi meme, birisi rahim kanseri ve ikisinin de yanında kaybediyorlar annesini ve babasını. Baya şeyi görüyorlar yani görmesinin yanı sıra gidişine şahit oluyorlar. Babamın panik atağı anneyi kaybettiği yaşta, annemin panik atağı da annesini kaybettiği yaşta başladı. Ablamda da ufak tefek böyle problemler var. Ben benim kendi çıkarımım aile aktarımının da olduğundan şüpheleniyorum çünkü şey yaşım ilerledikçe benim de 30'a doğru ilerledikçe kontrol edilemez bir benzer panik atak ve anksiyete bozuklukları göstermeye başladım.

Furthermore, Duru stated that her cousin bears a striking resemblance to her in terms of health anxiety. The onset of her cousin's anxiety was associated by Duru with her separation from the family due to being appointed for work.

> By the way, my cousin is experiencing the same thing as I am, the same symptoms, my cousin also has the same things. I think this is also a genetic transfer, exactly the same as mine. It's completely the same. It's completely the same. My cousin's father also died of cancer. It started before my cousin's father died. My cousin left the parents and was assigned to another city. It started afterwards. Both of ours similarly began when we left our parents.
>
> *Bu arada benimle aynı şeyi kuzenim yaşıyor aynı semptomlar aynı şeyler kuzenimde de var, onun için genetik bir geçiş olduğunu düşünüyorum ben de birebir aynı. Tamamen birebir. Onun da babasını işte kanserden kaybetti, babasını kanserden kaybetmeden önce başladı. Ailesinin yanından ayrılıp farklı bir şehre atandı, aileden ayrıldığında başladı onun da benim de aileden ayrıldığımda başlamıştı aynı şekilde.*

Illustrating how anxiety was rooted in the family, Beren said that her mother and her grandmother have always been more anxious individuals compared to the parents of her friends. Their anxiety levels increased especially when her mother was diagnosed with breast cancer when Beren was in the 5th class. According to her expressions, Beren did not lose her self-control at that time and her mother also tried to minimize the effects of her illness on her daughter's life. However, when the whole treatment process was over, the anxiety levels of both her mother and her grandmother increased, and her grandmother's overprotective attitude was directed to her. She also stated that she eventually became a person resembling her mother and her grandmother, although she did not want to be like that. The following extracts illustrated how the fear of losing loved ones such as children or grandchildren was rooted in the family background of Beren.

> (...) Let me talk about what kind of person my grandmother is, you know, she is worse than my mother (smiles), you know, just a little bit... I think it's because of, well, her family structure, and she comes from one of those old large families. You know how in those times there is such a thing as raising a child isolated from everything and even in the smallest things reacting like "Oh my child mustn't get sick, oh nothing must happen, oh she mustn't eat this and

that." You know, she has this thing about raising her isolated from everything. Like "I'll raise my granddaughters and daughters isolated from everything, protect them." My grandmother has such a disposition, and this reflected on me as well. You know, when I went to work and these healthy homemade things... She would always warn me like "Don't eat this, don't eat that." and stuff. Especially after my mother's cancer period, this time this thing started to shift a little towards me, you know, because my mother and I are related to the first degree and I carry that risk as well. You know "Oh nothing must happen to Beren", this time was aimed directly at me especially from my grandmother and mother. The reason I constantly mention them is because that is the biggest factor. You know, they began to experience this extreme health anxiety both due to my mother's illness and due to "Nothing must happen to Beren." For example, even in the smallest thing I receive this state of panic. When my throat gets swollen, my left lymph nodes swell as a natural defense mechanism, during my childhood or teenage years, my mother immediately panics saying "Your lymph are swollen, why did it get swollen, why did this happen." You know, for example, she feels something hard somewhere on my body or something as simple and she panics and tells my grandmother and my grandmother panics even more and tells us to immediately go to the doctor.

Early on of course they had this protective disposition but because it wasn't due to any illness as serious as cancer, it was at a normal level. Still, for example, when I talked with my other friends, I think at that time that ours was still a little too much. Because, I don't know, my mother wouldn't let us buy any Nutella, chocolate, or anything you know children love it but I shouldn't eat it. So, on the one hand I didn't have any of those habits, which is good for me, but the biggest short-coming is that, in my adulthood, **these have been coded in my brain in such a way that I am starting to resemble them even if I don't want to.**

(…) Anneannem de şöyle bir insan ondan da bahsedeyim hani o annemden daha da fenadır (gülümsüyor) böyle hani birazcık… Ben şeyden olduğunu düşünüyorum hani onun da aile yapısından ve böyle eskilerin kalabalık ailelerinden gelen bir insan. O zamanlar böyle çok şey en küçük bir şeyde böyle "Aman çocuğum hasta olmasın, aman ona bir şey olmasın, aman şunu yemesin, aman bunu yemesin." hani. Onu böyle her şeyden izole bir şekilde büyütmek gibi bir şeyi var torunlarını kızlarını. Hani "Her şeyden izole edeyim, koruyayım." böyle bir yapısı var anneannemin. Ve hani bu bana da yansıyordu hani böyle işte gittiğimde böyle sağlıklı şeyler hani böyle ev yapımı şeyler hep uyarıyordu işte böyle onları yeme bunları yeme falan vesaire. Ama annemin kanser sürecinden sonra özellikle bu sefer birazcık bu şey bana kaymaya başladı hani sonuçta annem 1. dereceden bir yakınlığım var bende de risk var sonuçta. Hani "Aman Beren'e bir şey olmasın.", bu sefer direkt bu şey bana anneannem ve annem özellikle hani böyle onlar tarafından sürekli onlardan bahsetmemin sebebi en büyük etkenlerin o olması hani böyle aşırı bir sağlık kaygısına girdiler onlar hem annemin hastalığından kaynaklı hem de bu sefer "Beren'e bir şey olmasın." Hani mesela en küçük bir şeyde böyle bir panik hali. Atıyorum benim boğazlarım şiştiğinde şu sol lenfim birazcık şişer hani doğal olarak vücudun savunma mekanizması ama mesela her böyle bir hastalığım olduğunda işte çocukken veya ergenlik dönemimde annem böyle hemen oraya bakıp "Lenfin şişmiş!" hemen böyle bir panik, "Neden lenfi şişti, neden böyle oldu." Veya hani atıyorum bir yerimde bir sertlik geldi eline veya basit bir şey hemen böyle bir panic, "Aman noldu", anneanneme söyler anneannem daha fena panik hemen doktora gidin.

Öncesinde şöyle hani elbet böyle korumacı bir yapıları vardı ama hani sonuçta hani böyle bir kanser adı altında bir hastalık veya bu kadar ciddi bir hastalık olmadığı için normal düzeydeydi. Ama yine mesela konuştuğumda diğer arkadaşlarımla hani o dönemlerde hani benimkilerin yine birazcık fazla olduğunu düşünüyorum. Çünkü böyle ne bileyim eve atıyorum annem böyle nutella falan aldırmazdı hani çocuklar çok sever nutella çikolata falan hani yemeyim ben diye hani bir yanım o zararlı alışkanlıkları küçük yaşta edinmedim bunun faydalı bir yanı var ama bunun işte en büyük eksiği bu sefer benim yetişkinlik dönemimde ***bunlar beynime öyle bir kodlanmış ki ne kadar istemesem de ben onlara benzemeye başlıyorum***.

Furthermore, while talking about what was going on in her life at the time of increase in her health anxiety, Gizem said that her family moved to another city. Gizem, associated the increase in her health anxiety with separation from her family and the process of becoming an individual. When she stated that this anxiety is period-specific, she was asked what it meant, and she replied:

(…) I live alone, separate from my mother and father, and feel more grown up, you know, trying to make a life for myself. It's no longer, you know, "I go to school, I come home, my mother and father send money, and I'll keep living like this." You know this period is when I'm really starting to become an individual and it involves coming to terms with death and experiencing its awareness. I think this feels to me like a painful transition into maturity.

(…) Hani yalnız kalıyorum annem babamdan ayrıyım daha büyümüş hissediyorum işte kendime bir hayat kurmaya çalışıyorum. Artık şey değil yani hani "Okula giderim, okuldan gelirim, işte paramı annem babam yollar, hayatıma bu şekilde devam ederim." değil. Hani gerçekten birey olmaya başladığım bir süreç ve bu süreçte ölümle yüzleşmek de bunun farkındalığını yaşamak da var bence. Yani bu şey gibi geliyor olgunluğa geçerken biraz sancılı geçiş gibi geliyor bana.

As seen in the extract above, loss does not only refer to death but also to separation process. Gizem also pointed out the similarity between her mother and herself in terms of fear of illness, and she said "My mother is also a bit like me, she is also afraid of sickness and such." ("Annem de biraz benim gibi bir insan, o da çok korkar hastalıklardan falan.") More importantly, she explained the similarity between herself and her mother in terms of fear of separation.

Yes (laughing) my mother, my mother is a little like me. She also cries instantly, for example when we speak, she instantly cries, I mean, she is also emotional. She also fears separation. She lost her father at a young age and my grandmother is a little, well, cold. I mean all the love and compassion towards my mother came from my grandfather.

(…) My mother was left alone, for instance, when I went to school here and we lived in Ankara for a period, I mean at that time my mother also had surgery

> and stuff, everything came one after the other, and my mother missing my father and thus being grumpy, and being really upset when sending my father and all that stuff. All of this of course, I mean, *is a* **constant reminder of how difficult it is to separate from someone***,* because him leaving was difficult and my mother couldn't get over it for a long time.
>
> *Evet (gülüyor) annem biraz annem de benim gibi. O da hemen ağlar mesela konuşsak hemen ağlar yani şey o da duygusal. Ayrılmaktan o da korkar, o da mesela babasını erken yaşta kaybetmiş anneannem biraz şey soğuk bir kadın, yani şey değil. Bütün sevgi ve şefkat dedemden geliyormuş anneme.*
>
> *(…) Annem yalnız kaldı mesela bir süre ben burada okula gittiğim için Ankara'da yaşadığımız için yani annem o zaman aynı zamanda ameliyat olmuştu şey olmuştu falan her şey üst üste geldi ve annemin o babamı özleyip aksileşmesi babamı yollarken çok üzülmesi falan. Hepsi tabi yani şey* ***birilerinden ayrılmanın ne kadar zor olduğunu şey yapıyor sürekli hatırlatıyor*** *yani çünkü onun gitmesi zor bir şeydi annem için uzun süre atlatamadı yani.*

Concerning the emergence of health anxiety, some participants indicated their predisposition to be anxious about loss even if not specific to health anxiety. Sevil, for instance, explained that although not focusing on health, she had obsessions when she was in primary school. The below extracts belonging to her showed that her obsessions were once again about death. She was afraid of losing someone close to her.

> Not particularly about health, but during primary school I had some obessions such as "I'll have an accident if I don't open this door while the car is going fast." Yes, when I say it now it was actually about death even then. You know, if I don't open this door, someone inside this car is going to die, and I would open the door while the car was going fast. I had things like that.
>
> (...) I remember even having it during middle school. When someone would come and just touch my desk, I would yell at them saying "What are you doing, move your hand". And I wipe the whole desk with a wet napkin and after cleaning where they touched I would not use the napkin anywhere else as if the germs on that hand would spread if I touched anything else. (…) Besides, there were things like germs spreading, **I was directly afraid of death** rather than illness and similarly losing people closest to me.
>
> *İlkokulda şöyle sağlıkla ilgili yoktu ama bazı takıntılarım vardı mesela "Araba hızlı şekilde giderken eğer ben bu kapıyı açmazsam kaza yapıcam." Evet, şimdi söyleyince orda da aslında ölümle ilgili. Hani bu kapıyı açmazsam birisi ölecek bu arabanın içinden diye ve araba hızlı giderken kapıyı açıyordum falan. Böyle şeylerim vardı.*
>
> *(…) Ortaokuldayken falan da vardı hatırlıyorum birisi gelip benim sırama şöyle elini dokunduğu anda ona bağırıyordum "Ne yapıyorsun, elini çek diyordum." Ve ıslak mendille tüm sırayı siliyordum ve onun elinin değdiği yeri sildikten sonra ıslak mendili başka hiçbir yere dokundurmuyordum sanki elindeki mikrop tekrar bir yere dokundursam yayılacak gibi. (…) Zaten mikrop bulaşma*

*o tarz şeyler vardı **direkt ölümden korkuyordum** hastalıktan ziyade en yakınlarımı kaybetmekten aynı şekilde.*

Related with this subtheme, during the interview with Gizem, she remembered an incident belonging to her childhood. She saw that having the hair dyed causes cancer in the news and then she called her mother in tears and asked her not to dye her hair anymore.

> I just remembered, for example, when I was little, this one time I saw on the news that dying hair caused cancer, but I was like 6 years old. I was with my aunts in Mersin and I called my mother and with tears asked her to please not dye her hair anymore as it caused cancer. Now that I think about it, it seems I was afraid even back then.
>
> *Bir de şimdi aklıma geldi mesela küçükken bir kere haberlerde saç boyasının kanser yaptığını görmüştüm ama o zaman yani 6 yaşında falanım böyle. Mersin'de halalarımla birlikteydim telefonla aradım annemi ve ağlayarak lütfen bir daha saçını boyatma kanser yapıyor dedim. Demek ki o zamanlar da korkuyormuşum şimdi düşününce.*

While talking about her health anxiety, Gizem also said how her already existing fear of death and the death of her aunt's husband affected her anxiety. She stated that she was afraid to die because of cancer or any illness that may lead to disability or deformation and to lose her parents due to an illness. As an influential factor, she explained that her aunt's husband died due to lung cancer and she could observe all the difficulties he experienced. Relating death with illnesses and being afraid of suffering from cancer other disabling illnesses were very common among participants.

> Actually, after the death of my aunt's husband, you know with my mother, I was always afraid of losing my parents when I was a child. After the death of my aunt's husband I realized something could happen to me as well, but it wasn't this intense. I think it started to intensify after the 12th grade when combined with the fear of death. I was a bit more comfortable before that.
>
> You know, for example, people are naturally afraid of their own death or something happening to them. For example, the thing I was afraid of most was having cancer, that terrifies me. My aunt's husband had cancer when I was in the 9th, no, 8th grade. He died when I was in primary school. It seems to me like that affected me a little.
>
> *Ya aslında eniştemin vefatından sonra hani annem ya hep aslında küçükken annemle babamı kaybetmekten hep çok korkardım. Eniştemin vefatından sonra kendime de bir şey olabileceğini anladım ama bu kadar yoğun değildi. Sanırım 12. sınıf sürecinden sonra çok yoğunlaştı hani ölüm korkusuyla birleşince. Ondan öncesinde biraz daha rahattım.*
>
> *Yani mesela insan kendi ölümünden korkuyor doğal olarak ya da başına bir şey gelmesinden. Örneğin, işte benim en çok korktuğum şey kanser olmak,*

ondan çok korkuyorum. Eniştem kanser olmuştu ben 9. yok 8. sınıftayken, ilkokuldayken vefat etti o dönem. O biraz etkiledi gibi geliyor bana kendimi.

Since she especially underlined that her health concerns increased when she was in the 12th grade, she was asked about what happened in that period. She stated that her mother had a surgery due to a cyst exploding in her ovaries and her parents moved to another city due to her father's job, while they were all living in Ankara together. She said that after her mother's health problem, she began to worry that something similar would happen to her. Thus, her mother's surgery did also affect her.

> Also my mother would, for example, my periods were painful and I would constantly go to a doctor about cysts. My mother had her ovaries removed due to a bursting cyst when I was in 12th grade. After that, this increased with me and I go to the doctor every month. Every month I go to a gynecologist and have them check for cysts just to be cautious and make sure nothing happens.
>
> *Bir de annem de şey mesela regllerim çok sancılı geçiyor sürekli kistle ilgili doktora gidip geliyorum. Annem ben 12. sınıftayken yumurtalıklarını aldırdı kist patladı. Ondan sonra da çok arttı bende hani sürekli her ay doktora gidiyordum. Her ay böyle şey kadın doğumcuya gidip benim kistim mi var bakın bir şey olmasın dikkat edelim falan filan.*

The interaction between the predisposition to be anxious and experiencing an event related to loss was also spoken out by Duru. She told that she was already an anxious person and she stated that her anxiety increases after her friend got cancer diagnosis and when a doctor misdiagnosed herself with lymph cancer.

> (...) Some 3 months ago my lymphs swole and I have a fear of cancer. My greatest fear is cancer. I had learned that a close friend of mine was diagnosed with cancer and when I went to the doctor after the swelling, the doctor immediately diagnosed me with lymphoma without doing any blood tests or anything particular. **I was already a person with anxiety.** After that my anxiety went through the roof.
>
> *(…) Bundan bi 3 ay önce lenflerim şişti ya benim kanser korkum var. En büyük korkum kanser. Yakın bir arkadaşımın öncelikle kanser teşhisi aldığını öğrendim ardından da doktora gittiğimde lenflerim şiştiğinde direkt olarak şey dedi bana lenfoma teşhisi koydu kan testi ve belirli bir şeyler yapmadan.* ***Ben zaten anksiyetesi olan bir insandım****. Ondan sonra anksiyetem ayyuka çıktı.*

In a similar way to Gizem and Duru, most of the participants also explicitly associated the emergence of their health-related concerns to experiencing, observing and/or anticipating a loss and the difficulties associated with those experiences. Some of them had an illness

experience themselves and they related their health anxiety with the illness itself or with the illness-related procedures. They established the association between illness and anxiety not only through the possibility of losing their lives but also losing their independence, power, and dignity. Ali, for example, stated that his anxiety began with his gastric bleeding. He suffered from it when he was 27 years old. When he was in the emergency service of the hospital to receive treatment, two individuals in the service died and that triggered his fear of death. He also said that he was afraid of experiencing similar health problems and medical procedures again.

> Researcher: What about that incident (suffering gastric bleeding and later witnessing deaths in the hospital) affected you this much?
>
> A: I mean lying there in a hospital environment, I don't know how to explain this, I mean the fear of death. After that, lying in that hospital again, getting a serum, an endoscopy, a colonoscopy all seem like torture to a person.
>
> *Araştırmacı: O olayın (mide kanaması geçirmesi ve sonrasında hastanede ölümlere şahit olması) nesi sizi bu kadar etkiledi?*
>
> *A: Yani hastane ortamında yatmak o yani bilmiyorum ki nasıl anlatsam yani ölüm korkusu. Ondan sonra yine bu hastanede yatacaksın serum yiyeceksin, endoskopi, kolonoskopi eziyet gibi geliyor insana.*

Moreover, he emphasized that his greatest fear is to become unable and to lose his dignity since he could not work for one year due to his health problems at that time and he thought that his relatives waited for his fall.

> Now I send my children to a private school and I don't have a second source of income. My wife doesn't work, I have no one, I mean I do these with one salary and my environment looks at me speculating what if I get sick again and suffer through these again. Constant illness (as I think of it) is like being bedridden all the time.
>
> *Şimdi ben çocuklarımı falan özel okulda okutuyorum mesela o şeyden ikinci bir kaynağım yok. Eşim çalışmıyor, yani kimsem yok, yani ben tek maaşla bunları şey ediyorum ve etrafım bana şeyle bakıyor nazari gözüyle bakıyor işte tekrar hastalanırsam işte bu şeylere düşersem gibisinden. Sürekli hastalık (düşünüyorum) sürekli yatalak gibi oluyorsun çünkü.*

Demet explained the onset of her health anxiety came after she suffered from facial paralysis, yet she did not indicate her health problem as the reason for her anxiety. She told that at that year she graduated from university and she felt pressure from her brothers about finding a good job and being successful. She said that she could not cope with these circumstances, and her health "obsessions" began. When she was talking about the meaning of illness, on

the other hand, she associated illness with incapableness. She mentioned her biggest fear as getting sick and being in need of care. When she was asked what incapability reminds her, she explicated that her father suffered from a stroke and lost his capabilities even the basic ones such as speaking. After this illness of her father, her mother gave all her attention to him and Demet said she felt very lonely at that time. In this case, Demet lost her mother's attention as well as the powerful parental figure.

> (…) I don't want to be helpless. I mean I know that situation so well I mean honestly it could be like this, now that you ask. When I was 6 years old, my father suddenly became paralyzed. He was a mountain of a man, a manager, his social life, umm, I mean he was that kind of guy. He is an angry, furious type, but he is an all aspects a dad. You know, he was huge. Then, suddenly, he suffered paralysis in the brain due to high blood pressure and sudden shocks of sadness. My mother took care of him for three years. I was 6 years old. How long did it last? It lasted until I was in the third grade. My mother and brothers would come to parent-teacher meetings.
>
> (…) My father couldn't talk. He suffered memory loss. He had been an accountant for years, in times when there weren't any computers. The man who could calculate everything himself could no longer multiply two and two. I was devastated in that period.
>
> *(…) Aciz olmak istemiyorum. Yani o durumu o kadar içinden biliyorum ki yani şöyle olabilir siz sorunca şu an açıkçası ben 6 yaşındayken babam felç oldu. Aniden dağ gibi bir adamdı, müdürdü, sosyal hayatı yani ıii çok şey bir adamdı. Babam hani sinirli öfkeli falan bir tiptir ama tam bir babadır. Hani böyle iri yarı şeydi. Bir anda yüksek tansiyondan ve ani üzüntü şoklar sebebiyle beyin felci geçirdi. Yaklaşık 3 yıl boyunca annem ona baktı. Ben 6 yaşındaydım. Yaklaşık kaç yaşıma kadar sürdü, ilkokul 3'e kadar sürdü. Veli toplantılarına falan annem abilerim gelirdi.*
>
> *(…) Konuşamıyordu babam. Hafıza kaybı yaşadı. Yılların muhasebecisi eskiden bilgisayar yok hiçbir şey yok her şeyi hesap kitap üzerinden yapan adam, ikiyle ikiyi çarpamıyordu yani yıkıldım bitiktim o dönem.*

The illness, however, did not have to be "real" as in the previous interviews. For example, Melis was mistakenly diagnosed with malignant melanoma, an aggressive type of skin cancer. Therefore, she was terrified with the possibility of the loss of her health or even her life. While she was explaining the reason why she was afraid especially of having cancer, she said:

> Now, for example, it (cancer) may have enveloped every part of us, and because there is no way to understand it from the outside and because it is a more serious issue, because death is, you know, more, for example, a higher probability.

Şu an mesela her yerimizi sarmış olabilir (kanser) ve dışardan hiçbir şekilde anlaşılmayabileceği için ve hani daha ciddi olduğu için, ölüm daha şey olduğu için, mesela yüksek ihtimal olduğu için.

When she believed that she had cancer, she thought that she initially tolerated it well and her anxiety had not started yet. After a biopsy, the doctor came to recognize that he was wrong. Then, she saw the doctor periodically for check-up only and her anxiety began in that period.

(…) (after she learned that she wasn't cancer) Afterwards I was going to checkups every 6 months for a year. Now it's once a year. I started to be afraid that something would show up. This one time something happened. A friend of mine's lymph got infected. Something rough showed up here, and since I've had surgery right here and heard the lymph, and she's explaining this saying I went to the doctor and the doctor felt it and did the thing with blood thinking there isn't anything serious. My friend never thinks of it herself, but I constantly think of cancer, then my arm got numb.

(…) (kanser olmadığını öğrendikten sonrası) Sonra 1 yıl 6 ayda bir kontrole gidiyordum. Şimdi yılda 1 oldu. Ya bir şey çıkacak ya bir şey çıkarsa diye çok korkmaya başladım. Hatta bir kere şey oldu. Bir arkadaşımın lenfleri iltihaplanmış. Burada pıtır pıtır bir şeyler çıkmış, ben de tam buradan ameliyat olduğum için lenfi bunu duydum anlatıyo anlatıyo anlatıyo doktora gittim, işte elledi, kan işte şey yaptı ciddi bir şey olmadığını düşünüyor. Ya onun hiç aklına gelmiyor ama ben kanser düşünüyorum sürekli sonra kolum uyuştu benim.

The anticipation of a loss could be the loss of the loved one, as well. Fadime said that her psychological condition got worse due to the problems in her nuclear family. She said that his father did not contribute to the family financially, and her mother struggled to run the household. Her father had also alcohol problems and he was coming home drunk. When her father came home late, he fought with his mother. Due to living in a boxy house, she witnessed all the quarrels between them. She said that she was worrying at nights as she thought that her mother would harm herself. Fadime told that her mother attempted suicide twice, since her father became unbearable for her. The following dialog showed that her anxiety had a relation with her fear of losing her mother.

(…) My father doesn't come and the anxiety hits me. Then, he comes again at around 12 midnight, and the fighting starts again. Of course, whenever the fight begins, I start to follow my mother because I think she will harm herself. Because my mother will leave us... She couldn't stand him anymore, she doesn't want to deal with him, can't deal with him. Her constitution can't handle it anymore. I mean, we don't want financial support, but as soon as he comes, he is drunk and doesn't sleep. You know how you sniff glue and how there is no sleep. When that happens, I worry that my mother will hurt herself. One day I followed her as she left home. Of course, she doesn't want to see or hear him, and I follow her to see what she's doing (speaks tearfully). She reached the end of the village and kept going through this garden, without noticing me. As she left the village I started being scared. I called to her saying

"Mom, mom", I said "where are you going, it's 2-3 in the middle of the night." "Shush" she said. At night, we're already afraid of dogs and stuff…
Researcher: So, where was she going?

F: To throw herself into the river.

Researcher: Isn't this your mother's second attempt?

F: Yeah, it's the second. I was 13 or 14 there. I mean, even since then, my psychologists (psychology) are damaged. I mean I had this fear at the family home.

(…) Babam gelmez tasa çöker bana. Şimdi yine gene gelir saat gece 12'lere yine başlar kavga. Eee ben kavga başladı mı anamı takip etmeye başlarım anam kendine garez edecek diye. Çünkü annem başımızdan gidecek… Annem çekemez oldu, onu çekmek istemiyor, çekemiyor, kaldıramaz oldu bünye yani. Geçim istemiyoruz ama (eve) geldi mi de sarhoş ya yatmıyor aynı estağfurullah tiner çekersin de nasıl öyle yatmıyor. O öyle olunca annem mutlaka kendine garez edecek diye bana bir tasa çöker. Bir gün takip ettim evden çıkıyor. Tabi, onu görmek duymak istemiyor annem. Ben de berisinden çıkıyom arkasından takip ediyom annemi napacak (ağlamaklı konuşuyor). Köyün sonuna vardı, köyün sonuna vardı gidiyo bu bahçeden öte, benden haberi yok. Köyden çıkınca korkmaya başladım. "Anne, annee" dedim "Nereye gidiyon saat gece 2-3". "Sus" dedi, "El duymasın sus." Dedi. Gece zaten korkuyoruz köpekten möpekten korka korka…

Araştırmacı: Nereye gidiyormuş yani?

F: Irmağa kendini atmaya.

Araştırmacı: Annenizin ikinci girişimi bu değil mi?

F: Hıhı ikincisi. Ben orda 13 yaşında mıyım 14 yaşında mıyım yani. Yani oralardan da var psikologlarım (psikoloji) ordan bozuk. Yani baba kapısında bu korku vardı üstümde.

Ali, Gizem, and Fadime mentioned the events they witnessed that are related to death and influenced them negatively. The person at the center of the event might be a (close) relative, as in the case of Gizem and Fadime, but it might also be a stranger, as in the case of Ali. The common point was that these events were significant because they evoke the fear of their own death and the death of loved ones. For Demet, on the other hand, her father did not die but he lost his authority and dignity after having a stroke. She was afraid of having an illness that may affect her vital functions, daily activities and social life. She described illnesses as humiliating.

All in all, the factors contributing to the onset of health anxiety were stated as loss related anxiety "running in the family", being already anxious about loss and experiencing, observing, and/or anticipation of a loss by the participants. Loss, hereby, refers to the loss of health, life and loved one due to an illness, death or separation.

3.2.2. Being Drawn into the Vortex of the Symptom

During the interviews, the expressions of participants pointed out how they could not stop themselves from being drawn into the things that they complain about or are afraid of. For example, while interviewing with the participant of the pilot study, her health-related career choice became salient for the researcher. She was a photographer but her main interest was childbirth photography. Although she said that she does not like to be in a hospital as a patient, she likes to be in the operating room during birth process because it is an exciting event. According to the results, health-related career choice or a wish to do so even if not choosing that career were verbalized. Ali was working as a health technician in the operating room of a hospital. He stated that he started to work in the hospital after having a gastric bleeding. When he was asked the impact of that period on him, his response illustrated how he was negatively affected by the environment of the hospital even though he had chosen to work there.

> I mean lying there in a hospital environment, I don't know how to explain this, I mean the fear of death. After that, lying in that hospital again, getting a serum, an endoscopy, a colonoscopy all seem like torture to a person. Then you have to watch what you eat and drink as if you will go through all of that again.
>
> *Yani hastane ortamından o yatmak, o yani bilmiyorum ki nasıl anlatsam, yani ölüm korkusu. Ondan sonra yine bu hastanede yatacaksın, serum yiyeceksin, endoskopi, kolonoskopi eziyet gibi geliyor insana. Onlar tekrar başına gelecekmiş gibi yemene içmene her şeyine dikkat ediyorsun.*

In the extract below, he explained the reason of why he likes his job; "being close to the doctors from various branches" and "being like a friend with doctors". Moreover, he stated that he gets examined by the doctors in his workplace every 3 or 4 months and he emphasized that he "keeps doctors near at hand" since he works at the hospital.

> I do this (his job) with love. I do it willingly. It's my own choice. Maybe it's because of this, because all the doctors are near at hand. I mean, for example, I don't want to work at another department. All the professors here are outside. For example, internal diseases. I mean, I'm on good terms with all of the doctors. There are lots of departments here like gynecology, general surgery, urology, and plastic and, for example, otorhinolaryngology. (…) I go to cardiology, then chest, and I can show all my blood work as it is near at hand because I'm already in the hospital. If there is a need to show these to other departments, for example, I go to these other departments with your (psychiatry) referral.
>
> *Bunu (mesleğini) severek yapıyorum. İsteyerek yapıyorum. Kendi tercihim. Belki de şundan da olabilir bütün hocalar elimin altında. Yani mesela başka bölümde çalışmak istemiyorum. Burada bütün profesörler mesela dışarıda. Mesela dâhiliye. Yani bütün hocalarla arkadaş gibiyim. Burada kadın doğum,*

genel cerrahi, üroloji işte plastik bir sürü bölüm var burada yani KBB işte atıyorum. (…) Kardiyolojiye gidiyorum, ondan sonra göğüs, bütün kan tahlillerim zaten hastane içinde olduğum için, bütün burada elimin altında olduğu için gösteriyorum yani. Eğer başka bölümlere gösterilmesi gerekirse mesela sizin hocaların (psikiyatri bölümü) yönlendirmesiyle o bölümlere gidiyorum.

He also stated that since he was also a medical staff, he knows what to do in case of an illness. According to his expressions, his fear of illness was decreased when he started to work but for the last two years it is as high as before. He explained there was an intense work pressure although he wanted to forget about his “hypochondria” by settling down to his job. However, when he goes away from work, he was worried that no one could help him. It can be said that being close to the hospital environment indicates being close to the people who can help him.

A: I relax when I go outside and wander… Maybe the hospital environment, the environment I work in, has overwhelmed me to such extent in these recent years. There’s my environment and the children’s expenses. When I go outside and get into the car, I just want to keep driving, you know, to forget, to look around. But I can’t stay where I go. For example, I go to my mother’s, to my hometown and say I’ll stay there for 3-5 days. But then I think what if something happens to me here, or this happens or that happens. Then, my blood pressure drops.

Researcher: You mean when you go farther...

A: The point I move further. For example, I just feel like it and go to Antalya, to Alanya and to have a vacation. When I arrive, what if something happens to me here? No one in the hospital environment, I mean what if no one helps me or I get sick here. What if I’m in a really bad situation. So, the next day or even that evening I return. I suffer from this a lot.

A: Şöyle rahatlıyorum ben dışarı çıkıp gezdiğim zaman… Belki de hastane ortamı, beni son yıllarda çalıştığım ortam, beni o kadar bunalttı ki. İşte çevrem, çocukların masrafları. Şu dışarı çıktığım zaman, arabaya bindiğim zaman, sürekli kullanmak yani unutmak istiyorum çevreyi görmek istiyorum. Ama gittiğim yerde de kalamıyorum. Mesela annemgilin yanına gidiyorum memlekete yani, diyorum ki 3-5 gün kalıcam. O zaman da diyorum ki ya burada bana bir şey olursa, ya şu olursa ya bu olursa, tansiyonum düşüyor işte.

Araştırmacı: Uzaklaştığınızda yani...

A: Uzaklaştığım nokta. Mesela uzaklaştığım, canım istiyor Antalya'ya gidiyorum Alanya'ya gidiyorum tatil yapayım. Oraya indiğim zaman, ya burada bana bir şey olursa, kimse bana hastane ortamından yani şeyde kimse yardım etmezse ya burada hastalanırsam ya çok kötü duruma düşersem. Bu sefer ertesi gün tekrar belki de o akşamı geri dönüyorum, çok muzdaribim yani.

Kübra was a student at a medical school. She told that her mother became pregnant with her brother at an old age, and she had problems with her liver. At that time, Kübra worried that his mother would die at birth. After her mother's health problems, she decided to be a doctor since she did not want to pick up any "second-hand" information and she wanted to access the right information herself. In this way, she thought that her anxiety would decrease, but it did not.

> In fact, I have chosen the wrong area of expertise. I mean when we were thinking about it as a family, we thought it would be wrong. My parents didn't want me to study medicine because they said I would be more afraid as I learned. I said I wouldn't be afraid and that I would learn the truth of things because now all I have is hearsay. However, it didn't turn out like that. While my mother was sick, we were looking at the doctor expectantly, waiting for something good to be said so we could relax. It was in that period that I decided. Otherwise, I actually wanted to study architecture.
>
> *Aslında çok yanlış bir alan seçmişim. Ya seçerken de aslında yanlış olabileceğini düşünmüştük ailece. İstemedi ailem zaten tıp okumamı çünkü öğrendikçe daha çok korkacaksın dediler. Ben dedim ki öğrendikçe korkmam, asıl hani asıl şey gerçeğini öğrenirim şu an kulaktan dolma bilgiyle. Ama öyle olmadı. Ben annemin bu hastalığında ya böyle doktorun ağzına bakıyorduk yani güzel bir şey söylesin de birazcık rahatlayalım diye. Sonra o dönem karar verdim. Yoksa ben mimarlık istiyordum aslında.*

Moreover, the following dialogue showed that in spite of the difficulty she experienced in gynecology internship, she said that she preferred to be a gynecologist.

> K: (...) During my gynecology internship, in my previous internship, something like this happened. I mean, I was afraid. Umm, it felt like my leg was going numb. Was it really going numb or was I imagining it, I wasn't sure about that either. But I was about to drop the internship. I couldn't come to the practices. I mean, that's how I get.
>
> Researcher: Which department do you want to work in the future?
>
> K: I want to be gynecologist (laughing).
>
> *K: (…) Ben işte kadın doğum stajındayken bir önceki stajımda böyle bir şey oldu, korktum yani ıı bacağım uyuşuyor diye hissediyordum artık uyuşuyor mu uyuşmuyor mu ben mi uyduruyorum orasını da bilmiyorum ama böyle baya stajı falan bırakacaktım gelmedim pratiklere falan hani öyle oluyorum.*
>
> *Araştırmacı: Siz hangi alanı istiyorsunuz ilerde?*
>
> *K: Ben Kadın Doğum istiyorum (gülüyor).*

She explained that "It seems to me that only gynecologists can give good news; your child is healthy or so." *("Bana şey gibi geliyor tek iyi haber verebilen doktorluk kadın doğum gibi yani*

çocuğunuz sağlıklı falan.") As seen both in the pilot study and in the cases of Ali and Kübra, they all stated a positive side, such as being close to the physicians and being more knowledgeable about health issues, of doing that job in addition to the negative connotations of the hospital environment. These positive sides were evaluated as an effort to gain control over.

Although Gizem did not chose such a career, she explained her need to have everything under control and following this, she mentioned her wish to be in the hospital environment with her loved ones to guarantee that nothing bad will happen.

> G: (…) Controlling everything, being wary of everything. It seems like I would be very happy in a hospital room with an internet connection and all the people I love are with me. It feels like we would be really happy in a clean room where no harm may come.
>
> Researcher: But it is a hospital environment.
>
> G: Yeah but you know, for example, in the same room or the kind of place with a few rooms and we are together. What if we were together and no harm would come from the environment, I don't know, from earthquakes and this and that. What if it were durable against everything? It seems like I would be really happy. Everything would be good (laughing).
>
> *G: (…) Bir her şeyi kontrol edeyim, her şeyden sakınalım. Şeyde olsam çok mutlu olurmuşum gibi geliyor böyle bir hastane odası böyle internet bağlantım falan var, işte bütün sevdiğim insanlar da benimle birlikte. Böyle tertemiz hiçbir zarar olmayacak bir odada birlikte olsak çok mutlu olurmuşuz gibi geliyor.*
>
> *Araştırmacı: Ama hastane ortamı.*
>
> *G: Yani ama şey mesela aynı odada nasıl böyle bir yer birkaç oda hani birlikte olsak çevreden hiçbir zarar gelmeyecek olsa. Ne bileyim depreme, şuna buna her şeye dayanıklı olsa. Çok mutlu olurmuşum gibi geliyor. Her şey çok güzel olabilirdi (gülüyor).*

In addition to the health-related career choice of the participants, the second salient theme was preoccupation with precautionary behaviors including examination of the body even for the small changes, web search to get information on and control their symptoms, frequently going to the doctors to check their health condition and paying exaggerated attention to their lifestyle habits such as nutrition. However, these behaviors sometimes had counterproductive results: their anxiety level increased rather than decreased.

Beren's health anxiety began after she was diagnosed with genital herpes. She stated that following the healing, she started to be afraid of its recurrence. Moreover, her complaints about her genital region continued for a while, but nothing could be found by the physicians. Then,

she got post-herpetic neuralgia diagnosis which appeared as a consequence of genital herpes. She clearly explained how she was receiving care of her health even more after these health problems, however, these efforts sometimes led to unwelcome outcomes.

> (…) This time it's okay, I have relaxed, you know, the diagnosis has been given (postherpetic neuralgia). I take my medication. I am fine now, but afterward where I used to have anxiety about that moment, now, after this process, it started to turn into anxiety about what might happen in the future. All right, I have a disease now and I'm in the process of treatment, but what if this medicine loses its effectiveness in the future, what if my problems start again, what if I get warts again afterwards because it is already a sensitive area. How should I say this, I suffered through a serious and painful disease and I'm really afraid of going through that again. After that, by the way, the warts didn't reappear. One time there was a very mild one, but I took my medicine and it healed immediately. I never suffered it as painful as I used to. But, like I said, this time the anxiety I felt back then evolved towards the future. This time what started to happen was, I was already a careful person with my food, etc. I don't consume unhealthy things, and by unhealthy, I mean acidic drinks, fast food, and things with sugar. I have always been like this; "I would watch what I eat." But after this, "I have to keep my immune system high for this wart not to reappear.", so I have to really watch what I eat. This time I had to impose the limitations I placed on myself and started to avoid things. For example, stuff like dried nuts can be a trigger for this thing, this genital wart and other infections. Then, for example, I used to love dried nuts and this evolved into "I should not eat them." For example, sweets have an adverse effect on my immune system and I absolutely shouldn't consume any. When I consumed them, my anxieties started to increase because my brain says to me "you ate this sweet, you consumed it, and this will be very bad for you." This time, you know, the feeling that something's going to happen constantly repeats in my brain. I mean I have these thoughts.

> *(…) Bu sefer tamam, rahatladım, hani teşhis kondu (postherpetic neuralgia). İlacımı kullanıyorum artık iyiyim, ama sonrasında bu sefer şey oldu, önceden o anla ilgili kaygılarım varken, şu an bende ne var kaygılarım varken bu süreçten sonra acaba ilerde ne olur kaygısına dönüşmeye başladı. Tamam, şu an bir rahatsızlığım var tedavi sürecindeyim ama hani ya ilerde bu ilaç etkisini kaybederse ya şikâyetlerim tekrar başlarsa ya tekrar uçuk geçirirsem ondan sonra çünkü birazcık hassas bir bölge zaten. Nasıl desem hani çok ağır ve ağrılı bir hastalık geçirmişim ve hani tekrar yaşanmasından çok korkuyorum. Ondan sonrasında bu arada uçuk hiç tekrarlamadı, hiç. Bir kere böyle hafif bir oldu, ilacımı aldım hemen geçti. Hani hiçbir zaman o kadar ağrılı yaşamadım. Ama dediğim gibi bu sefer o anda duyduğum kaygı geleceğe evrildi. Bu sefer şey olmaya başladı, zaten ben yiyeceklerime vesaire çok dikkat eden bir insandım böyle zararlı şeyler, zararlı şeyler dediğim asitli içecekler tüketmem, fast food yemem, ondan sonra şekeri tüketmem. Hani hep böyleyim, zaten dikkat ederdim. Ama bunun sonrasında şey olmaya başladı "Benim bağışıklık sistemimi çok yüksek tutmam lazım, bu uçuğun bir daha tekrarlamaması için, o yüzden ben yiyeceklerime çok dikkat etmeliyim." Bu sefer kendi kendime hani aslında kendi koyduğum sınırları bir zorunluluk haline getirdim birazcık böyle şey sakınmaya başladım. Mesela atıyorum araştırıyorum falan, böyle kuruyemiş mesela bu şeyde tetikleyici olabiliyormuş bu genital uçuk ve diğer enfeksiyonlarda o zaman mesela kuruyemiş yemeyi çok severdim kuruyemiş kesinlikle yememeliyime evrildi. Mesela şeker, ondan*

sonra bağışıklık sistemine kötü etkisi var kesinlikle tüketmemeliyim ve tükettiğimde anksiyetelerim aşırı derecede artmaya başladı. Çünkü mesela şey beynim şey diyor mesela hani "Sen şu an bu şekeri yedin şeker tükettin ve bu sana çok zararlı olacak." Bu sefer hani sürekli şey bir şey olacak bir şey olacak bir şey olacak hissi sürekli beynimde şey olmaya başlıyor düşünce oluyor yani.

Ada explained that she consistently examined her body to see if there was a bulk, since her anxiety focused primarily on cancer. She also mentioned that she was thinking about eating healthy; but there were also things that she did not pay attention to, such as smoking. As a result, her fears got stronger.

I already constantly examine my body whenever the smallest mole appears or, for example, I look to see if there is any mass. I mean I pay attention to its changes. In fact, beyond the changes, I think about it a lot with the things I eat and drink. But, on the one hand, there are things I don't pay attention to as well. For example, things like smoking. So, as a result, it actually creates a little fear. I mean, the inability to take care of my body that well also gives me fear because there are things in my hands. There are things I can do to protect myself, but I don't do them and I'm actually afraid of this as well.

Ben bedenimi zaten sürekli inceliyorum, en ufak bir ben çıktığında veya mesela vücudumda herhangi bir kitle var mı diye sürekli bakıyorum. Yani değişimiyle çok ilgileniyorum aslında. Hatta değişimden öte yediğim içtiğim şeylerde de çok düşünüyorum. Ama bir taraftan dikkat etmediğim şeyler de var, yani elimde olmayan şeyler de var. Mesela sigara içmek gibi. Yani o yüzden aslında o da biraz korku yapıyor yani bedenime çok iyi bakıyor olmamam da bana korku yapıyor çünkü tamam elimde olan şeyler var. Hani kendimi korumak için yapabileceğim şeyler var ve onları yapmıyorum bundan da korkuyorum aslında.

Additionally, participants expressed that they searched the web to gain more knowledge about their symptoms, although they knew that e-resources had a pessimistic viewpoint. Ada stated that she could not stop searching on the Internet even though she knows that every symptom carries a possibility of cancer according to the internet.

(…) It's always as if I am going to become cancer, as if I have its symptoms. Also, when have a problem, I first research it on the internet. They say not to look at the internet, but I still can't resist looking and there it always leads to some kind of cancer. Even the smallest symptom or headache leads to that and a possibility forms even if it is zero point zero percent.

(…) Sürekli sanki kanser olacakmışım gibi onun bulguları varmış gibi. Bir de bir şeyim olduğunda mesela internette araştırıyorum ilk yani. İnternete hani bakma diyorlar hani çok şey diyorlar ama ben yine de dayanamayıp internetten bakıyorum ve orda mutlaka belli bir kansere çıkıyor onun yolu. Yani en ufak bir belirtinin bir baş ağrısının bile yolu ona çıkıyor ve bu hani yüzde sıfır nokta sıfır bir bile olsa bir ihtimal oluşturuyor.

She explained that the reason for searching the web was to control her symptoms and eliminate even a slight possibility of being cancer. She said: “I feel the need to directly control, you know, whether or not I need to go to the doctor, I want to eliminate that possibility.” (“*Kontrol etme ihtiyacı hissediyorum direk hani doktora gitmeye (gerek) var mı yok mu, o ihtimali (kanser) ortadan kaldırmak istiyorum.”)*

In addition to searching on the Internet, Sevil said that she regularly gives a blood test. In her opinion, if she has cancer, the test would tell it.

> S: I constantly get my blood checked because if my mother, for example, learns that I go to the doctor on suspicions of cancer, she will get really angry about it. That’s why I get my blood checked and I do this regularly so if there is something, it will show up.
>
> Researcher: How frequently?
>
> S: Every 3 months. I think that if there is something, it will reflect there. That’s why I go to the doctor. Also, unfortunately, I search everything on Google and I wish I had never been aware of this. My head aches and I look at it straight away. Good thing my aunt is a doctor, otherwise I could have been going to the doctor every day.
>
> *S: Kan değerlerime sürekli baktırıyorum çünkü annem eğer atıyorum kanser olduğum düşüncesiyle doktora gittiğimi öğrenirse gerçekten çok sinirlenir bu konuya. O yüzden kan değerlerime baktırıyorum ki bunu düzenli yaptırıyorum hatta hani bir şey varsa oraya da yansır.*
>
> *Araştırmacı: Ne kadar sıklıkla?*
>
> *S: 3 ayda bir. Hani bir şey varsa oraya da yansır diye düşünüyorum. O sebeple doktora gidiyorum. Bir de maalesef her şeyi Google'da aratıyorum ki keşke bunun hiç farkında bile olmasaydım. Başım ağrıyor direk bakıyorum. İyi ki teyzem doktor yoksa her gün doktora gidiyor da olabilirdim.*

She stated that the function of going to the doctor was to be sure that nothing is wrong with her and to be relaxed.

> For example, if I cough through my lungs a lot for a quite a while, I think that I probably have lung cancer; but if I go to the doctor and am sure of it, I won’t care.
>
> *Mesela uzun bir süre çok fazla ciğerlerimden öksürüyorsam herhalde akciğer kanseri oldum diye düşünüyorum; ama eğer doktora gittiysem ve bundan eminsem umursamam.*

Since Sevil's aunt was a doctor, she was frequently contacting with her. She said that by doing this she could relax for a while.

> (…) Concerning asking something I'm curious about, I just send a message at night because I'm ashamed to call now, because I do this almost every week. I research on the internet. For example, recently my hands were flaky, and I looked at the internet, straight up it wrote eczema. I waited for nightfall and began to write… Every message was the same. I think she also knows the reason. I write "You might be asleep; sorry I couldn't call. There's this stuff on my hands. I'm sending a photo.", and then I send a photo.
>
> (…) She never replies with a text, she calls and says "Yes I saw it now, that probably isn't eczema, but if you don't want any doubts left in your head, you can go to internal medicine instead of directly going to a dermatologist and give some blood. And this suits me really well because then I can see all my other results (laughing). On this topic, actually, it doesn't help so much. It just comforts me temporarily. In the end, I think, she is also a doctor amd she should recognize it immediately if it really is eczema. I mean, at that moment I think "All right, she may be a family physician, but a doctor nonetheless."
>
> *(…) Merak ettiğim bir şeyi sormak konusunda direk zaten gece mesaj atıyorum çünkü aramaya utanıyorum artık çünkü nerdeyse her hafta yapıyorum bunu. İnternetten araştırıyorum. Mesela hatta en son ellerim pul pul dökülüyordu, internetten baktım direk egzema yazıyordu. Gece olmasını bekledim ve şey yazıyorum… Her mesaj aynı. Bence o da biliyor artık sebebini bunun. Hani "Uyuyorsundur diye arayamadım, kusura bakma ellerimde böyle böyle bir şey var.", fotoğrafını yolluyorum.*
>
> *(…) Hiçbir şekilde mesajıma yazarak cevap vermiyor, arıyor, şey "İşte şimdi gördüm, o egzama değildir, ama istiyorsan kafanda kalmasın, hani şey direk cildiyeye değil de bir dâhiliyeye git istiyorsan bir kan ver diyor." Ki bu çok işime geliyor, diğer sonuçlarımı da görecek oluyorum (gülüyor). Bu konuda, yani aslında çok da bir yardımı olmuyor. Sadece kısa süreli beni rahatlatıyor. Şey diye düşünüyorum "Sonuçta o doktor bunu gördüğünde eğer gerçekten egzamaysa gördüğü an tanıması gerekir." diye düşünüyorum hani "Tamam aile hekimi ama sonuçta doktor." diye düşünüyorum o an.*

İrem, on the other hand, used the Internet not only to find out the reasons of the symptoms in her body but also to learn about other people's experiences with cancer. The coexistence of fear and enjoyment in this behavior was clearly stated by her.

> (...) The thing I like most during the day is I read a lot of cancer blogs. I read the blogs of patients who are terminal, about to die. I make sure I read those blogs every night before I sleep and never with concern. I constantly have this situation of imagining and following their suffering process, how they die, and what is experienced.
>
> *(…) Benim gün içinde benim en zevk aldığım şey ben çok fazla kanser blogu okuyorum. Terminal, ölmek üzere hastaların bloklarını. Ve her gece uyumadan önce muhakkak onların bloglarını okuyorum ve hiç kaygıyla*

okumuyorum. Ya o acı çekme süreçlerini, nasıl ölüyorlar filan, ne yaşanıyor, sürekli onları bi imajine etme takip etme halim var.

When she was asked what attracts her attention most about this situation, she responded:

> I mean, nothing specific but, for example, I don't read the second stages, in which I get a cancer diagnosis. Such things as 4th stage cancer diagnosis, terminal, that will definitely die, I mean will they die in 2 years, how do they die, you know, how that process happens, how they deal with it, how they suffer, does anyone announce it; I wonder about that. I have such a thing and I don't read this with concern. I mean, I don't know, I read it like someone reads a novel that they really like; and even when I don't have anxiety about cancer, I have a habit like this. This is what I was doing in those 5 years. The disadvantage of this is that you know all the symptoms related to cancer really well. I mean, as I read those blogs, inevitably, not like a doctor of course. I'm already in a state of overinterpretation and I could count the symptoms of any cancer you ask to the smallest detail.
>
> *Yani hani spesifik şey değil de şey mesela normal kanser tanısı aldığım ikinci evreleri okumuyorum. İşte 4. evre kanser tanısı, terminal, kesin ölecek yani 2 yılda mı ölür, nasıl ölüyorlar, yani o süreç nasıl oluyor, nasıl deal ediyorlar, nasıl acı çekiyorlar arkalarından birisi duyuruyor mu onların yani onu merak ediyorum. Öyle bir şeyim var ve hani bunu kaygıyla okumuyorum. Yani ne bileyim bir insanın çok sevdiği bir romanı okuması gibi okuyorum ve bu kanser kaygım olmadığında da böyle bir alışkanlığım var. Yani o 5 yılda da bunu yapıyordum. Bunun dezavantajı hakikaten kanserle ilgili bütün semptomları da çok iyi biliyorsun. Yani o blokları okuya okuya yani ister istemez tabi doktor gibi değil de. Hani zaten bir overinterpretation halim var en ufak bir yani en ince ayrıntısına kadar hani şu kanserin semptomu ne desen sayarım yani öyle söyleyim.*

She expressed that she felt the need to observe the death process of cancer patients and she wondered how those patients describe their pains.

> (…) That is a need to observe but I'm not sure why I feel that need. I want to see what that death and pain process is like. They lose their jobs, become unable to move, and the way they describe their pain, all of it is curiosity.
>
> *(…) Bir gözlemleme ihtiyacı yani ama o niye gözlemlemek ihtiyacı içindeyim ondan çok emin değilim. Görmek istiyorum yani nasıl bir şey o ölüm süreci, acı çekme süreci. İşlerini kaybediyorlar, hareket edemez hale geliyorlar atıyorum işte acılarını tarif edişleri falan işte merak yani.*

Lastly, some participants said that they were overthinking about the bad things, such as illness or death, that might happen in the future. Gizem mentioned that she excessively "dreams" about the things that will happen after her death.

(…) I think I **dream** too much. In my opinion, to imagine something too much and have such an unnecessary, for example, I won't know what happens in life after I die so naturally there is no need to feel upset. Yet, I imagine that, like, I dramatize the situation by saying "I wonder how it's going to be." That's not good for me.

*(…) Fazla **hayal ettiğim**i düşünüyorum. Bence bir şeyi fazla hayal edip böyle hani yani gereksiz bir şekilde, mesela ben öldükten sonra hayatta ne olduğunu bilmiycem doğal olarak üzülmeme de gerek yok yani. Ama işte onu hayal ediyorum işte "Nasıl olacak acaba falan filan." diye o durumu dramatize etmiş oluyorum yani hani o bana kötü geliyor.*

The purpose of such a priori thinking was not known by Gizem. In fact, she was evaluating it as unnecessary. However, Ada's explanation gave an idea about what might be the function of thinking too much on bad things such as death, accident, or illness. She said that she did not lose any person she loved or she never experienced any illness. However, she thought bad things could happen to her or her loved ones and in this way, she was preparing herself to them.

Ever since childhood I have never personally come across anything bad and neither have I come across things like illnesses, accidents, or deaths in my family. I mean, the most minor person that I love, excluding really distant relatives of course, I mean, I have never lost someone I love and never have come across any serious problems about myself. Maybe that is why I am afraid.

(…) I think these might also happen to me, you know, I kind of prepare myself against such things by thinking that the people who go through those bad things might be me or the people I love. I mean, I also do that frequently, against bad things. Because I really fear going through bad things, I feel the need to constantly prepare myself for them. I think about bad things happening to those I love. Sometimes I imagine them happening to me, and I sort of prepare by thinking about what may happen then. (…) It feels like experiencing something that I know of and have prepared for will make me feel a little more comfortable. It feels as if my reactions will be a bit less. I mean, I distribute that pain, or, to be more precise, I distribute it over time. Instead of feeling a lot of pain then, preparing a little before that time makes me feel better.

(…) Hani küçüklükten beri kötü bir şeyle hem kendim karşılaşmadım hem ailemde herhangi bir insanda bir hastalık bir kaza ölüm gibi bir şeyle hiç karşılaşmadım. Yani en ufak bir sevdiğim insan bile, çok çok uzak akrabaları tabi ki es geçiyorum, yani sevdiğim hiçbir insanı kaybetmedim ve kendimde de büyük bir sıkıntıyla karşılaşmadım. Belki bu yüzden hani korkuyor da olabilirim.

(…) Kendi başıma gelebileceğini de düşünüyorum, hani o kötü şeyleri yaşayanların benim veya benim sevdiğim insanlar olabileceklerini düşünerek daha hani bir nevi kendimi hazırlıyorum da öyle şeylere. Yani ben onu da çok sık yapıyorum, yani kendimi kötü şeylere kötü şey yaşamaktan çok korktuğum

için ona kendimi sürekli bir hazırlama ihtiyacı hissediyorum. Yani sevdiklerime bir şey olduğunu düşünüyorum. Bazen kendime bir şey olduğunu düşünüyorum ve o zaman ne olacağını düşünerek bir nevi hazırlık yapıyorum. (…) Yani bildiğim önceden kurduğum bir şeyin yaşanması biraz daha beni rahatlatacak gibi. Sanki tepkilerim bir tık da olsa azalacak gibi hissediyorum. Yani o acıyı paylaştırıyorum, daha doğrusu zamana paylaştırıyorum. Yani o zaman çok fazla acı çekmektense birazcık daha önceden hazırlık yapmak bana daha iyi hissettiriyor.

Participants' choices, behaviors, and thoughts seemed to be contradictory. When they were asked questions to understand how they interpret these situations, they sometimes answered that they did not understand and know why, but the underlying reason, according to their statements, was as an effort to have a grip on the things they feel anxious about by getting into it even more deeply. Although, they stated that their efforts to maintain control over their health anxiety often did not work and that they felt even more anxious, and they could not stop to do that.

3.2.3. An Endless Call to an Expert for Naming Own Experiences and Eliminating Uncertainty

One purpose of the study was to understand how individuals with health anxiety form an interaction with health care professionals, and to understand their expectations from them, since they frequently, and sometimes obsessively, encounter them. For that purpose, questions related to their relationships with health care professionals and their expectations from them were asked. According to their responses, participants need physicians for the naming of their experiences to make sense of them and for the elimination of their doubts about their health conditions, yet the need for information and clarity was not independent of care. Gizem exemplified how knowledge was intertwined with care.

It's very important that the doctor is wise and someone I can trust. The doctor's attitude is also very important. I mean, if it is someone who doesn't care about me or isn't very knowledgeable and uses broad terms, I'll feel uncomfortable. Even if it's nothing, I would want to be examined it just in case. For example, if the doctor sees me and says, "There is nothing wrong with you", you know, "If it were this, you couldn't stand" and "You can go home", I won't trust the doctor at all. The doctor needs to say "Nothing will happen, but let's test you anyway" for me to feel better.

Ya doktorun şey bilgeli ve güvenebileceğim bir insan olması çok önemli. Tavrı da çok önemli. Yani beni umursamayan bir insansa ya da çok bilgili olmayıp geniş şeyler söylüyorsa ondan rahatsız olurum. Bir şey olmasa da incelenmek isterim yani nolur nolmaz. Hani doktor mesela beni gördü dedi ki "Bir şeyin yok." hani "Böyle olsa böyle duramazsın." dedi, "Gidebilirsin." derse ben hiç

güvenmem yani. "Bir şey olmaz ama yine de test edelim." demesi lazım benim iyi hissetmem için.

Ali's following statements could be another example showing that the only thing expected from physicians and as a researcher from me was not information.

> The doctor across from you has to give you confidence. You know, like saying we will beat this together, you will use this medicine, or follow these instructions, or my phone is available. When you call you need to **be able to chat like a friend**. This is what you seek in hypochondria. The one in front of you, for example Ms. S, or when I come to you. Your name was Pınar right? If Ms. Pınar could say "**We will beat this illness together.",** or when I call, (if she should say) that is normal. In this disorder, the moment you say normal, the headache goes away. The headache goes way at that moment or if I get sick, I mean in the future, I mean I'm saying this for your profession, to be with you, to visit you, for example at that moment the illness subsides. Trust, or trust towards the doctor, because I look at some doctors and they are just doctors from a knowledge perspective. Sometimes it doesn't feel satisfying.
>
> *Yani karşındaki doktorun sana güven vermesi lazım. Yani bunu beraber yeneceğiz, bu ilacı kullanıcaksın veya şu telkini yapacaksın veya işte telefonum açık. Aradığın zaman **arkadaş gibi dertleşebileceksin**. Öyle arıyorsun bu hastalık hastalığında. Karşıdaki, mesela S. Hanım ya da sizinle geldiğim zaman. Pınardı değil mi isminiz? Pınar Hanım dese ki "**Bu hastalığı beraber yenicez.",*** işte aradığım zaman *o normal (dese). Bu hastalıkta normal dediğiniz zaman, o anda başının ağrısı geçiyor zaten. O anda başının ağrısı geçiyor veya bir hastalansam yani ilerde yani sizin mesleğiniz için söylüyorum, yanınızda olması, ziyaret etmesi, mesela o anda hastalığınız zaten geçiyor. Güven yani güven, karşıdaki doktora güven, çünkü bazı doktorlara bakıyorum yani sadece doktor olmuş. Yani bilgi yönünden yani doyurucu gelmiyor bazen.*

Hence, for these participants, being knowledgeable was not sufficient to be "a good physician". They expect the physicians' attention and care as well. However, their expectations were not met at all or met only temporarily, because of their ambiguous expectations or the uncertain nature of issues related to illness and death. Therefore, most of the participants complained that they were not understood and sufficiently cared by the physicians.

Ada, for example, stated that a physician should continue to search until being precisely certain that the patient does not have any illness, and she was expecting physicians to speak on her behalf. She said that illnesses can progress in a hidden way without any obvious symptoms, so an ideal physician should consider each possibility. She added that physicians should take care of each patient "too much".

(…) Actually, I think like this. If that person is a doctor, I imagine that he/she must continue being a doctor until certain that the person in front of them has no illness. That is how I picture it in my head. I think they need to take care of each patient too much and be certain that there is not the slightest problem. However, that is not how it usually happens. Especially when you go to a state hospital, it doesn't occur like this. They just ask your symptoms; but there are sometimes things that I don't realize myself. There are problems that I can't explain as well. For example, when I go to a psychiatrist, when asked "Why do you think this is?", I can't always verbalize it or put it into words. So, I want them to be more open, more inquisitive until they are certain, but that doesn't happen.

In my opinion, an ideal doctor must evaluate all of the illnesses and think of every possibility while trying to find the cause of a sickness in order to make sure that nothing has been overlooked. In the end, there are things in the body that progress unseen. I mean, it doesn't necessarily have to occur in the same severity. The beginnings of illnesses are usually mild and become more severe later on. I want them to always be certain of this. I want them to think of every possibility. Yet, it doesn't happen like this.

(…) Aslında şöyle düşünüyorum. Hani bir doktorsa eğer karşındakinin herhangi bir hastalığı olmamasından emin olana kadar doktorluk yapmasını düşünüyorum. Hani kendi kafamda o şekilde kuruyorum. Yani her hasta ile çok fazla ilgilenmelerini ve en ufak bir sıkıntısı olmadığına tamamen hani emin olmaları gerektiğini düşünüyorum. Ama böyle olmuyor genelde hani. Özellikle devlet hastanesine gittiğinizde böyle olmuyor pek. Sadece semptomlarınızı soruyorlar ama benim kendim hani fark edemediğim şeyler de oluyor aslında. Dillendiremediğim sıkıntılarım da oluyor. Mesela bir psikiyatriste gittiğimde de, bana "Şu şu neden sence?" dediğinde, ben onu her zaman kelimeye vuramıyorum, her zaman söze vuramıyorum. Yani biraz da onların daha açık ve sorgulayıcı, sonuna kadar emin olmak ister şekilde olmalarını istiyorum ama böyle olmuyor.

İdeal bir doktor her ihtimali bence düşünmeli. Belli bir şeyin, belli bir sıkıntının aslında hastalıkların hepsini düşünüp hangi hastalığın ona neden olduğunu düşünmeli ve hepsinden bence emin olmalı. Sonuçta vücutta gizli ilerleyen şeyler de var yani. Sürekli hep aynı şekilde çok fazla şiddetli olacak diye bir şey yok. Hastalıkların başlangıcı genelde zaten hafif oluyor yani sonra sonra şiddetleniyor. Bundan ben hep emin olmalarını istiyorum yani her ihtimali düşünmelerini. Ama öyle olmuyor.

Likewise, Öykü complained that physicians could not speak for sure: "Doctors do not speak very precisely, or could not make a concrete, scientific explanation." ("Doktorlar çok kesin konuşmuyorlar, ya da ciddi elle tutulur bilimsel bir açıklama yapamıyorlar.")

Melis verbalized that her physician should be sympathetic and empathetic so that he or she could understand her. She said she did not want a patient-doctor relationship that she had to explain her illness.

(…) I don't like these morose doctors. Also, for example, when I got to ultrasound checkups, I don't like those who make that "hmm hmm" face because I fear they see something. I like doctors that are sympathetic, empathetic (laughing). They should understand and such. I like doctors like that, but those morose, scolding, I don't know, those who always ask your illness or, for example, I tell the secretary I am going to have an ultrasound and she asks me what my complaint is. Now, my story is so complicated, I used to get upset and angry saying "Why should I explain this to you, I already live through it while explaining it."

(…) Böyle şey suratsız doktorlar sevmiyorum. Bir de hani mesela ultrason kontrollerine girdiğim zaman, "ımm ımm" surat yapanları sevmiyorum çünkü bir şey gördüğünden korkuyorum. Ya böyle insan sempatik olsun, empatik olsun (gülüyor). Anlasın falan, öyle doktorları seviyorum. Ama hani böyle suratsız işte tersleyen, ne bileyim sürekli hastalığını soran, ya mesela sekretere ultrasona giricem sekreter bana neyiniz vardı diye soruyor. Şimdi benim hikâyem de o kadar karışık ki "Ben sana niye anlatayım, anlatırken yaşıyorum zaten tekrar" deyip işte kızıyordum, sinirleniyordum.

Besides, the following extract of her showed how she expects decisive statements from physicians about illness and death.

I used to always ask the doctors if I was going to die. In fact, one of them said "yes" one day (laughing). "I mean I can't tell you that you won't die, maybe you'll have an accident on your way out," and I used to say "Oh, I don't want to hear that." I would frequently ask if these things would happen again, if I would suffer these again. I would continually be afraid of these.

Ölecek miyim diye soruyordum sürekli doktorlara. Hatta bir tanesi bir gün evet demişti (gülüyor). Yani ben sana ölmeyeceksin diyemem, belki çıkınca kaza geçireceksin, "Yaa ben onu duymak istemiyorum." diyordum. Sürekli onu soruyordum, yani tekrar olacak mı, tekrar başıma gelecek mi bunları soruyordum. Habire bunlardan korkuyordum.

İrem explained how she could not fully relaxed despite being taken to a physician whom she wanted to go, since she thought that they failed to detect her problem.

Am I cancer? I went to the doctor a few times, I mean, to different doctor and was always thinking they missed something. There is definitely cancer here but they can't find it. Then I would whine and cry, telling them to take me to a better doctor, you are not taking me to the doctor I want. But there was this situation of not relaxing much even if they sent me to a new doctor.

Kanser miyim? Birkaç defa doktora gittim, yani farklı doktorlara ve hep şeydim bunu gözden kaçırıyorlar. Kesinlikle hani burada kanser var ama bulunamıyor. Daha iyi bir doktora götürün beni diye mızmızlanmalar, ağlamalar, benim istediğim doktora götürmüyorsunuz diye. Ama istediğim doktora götürünce de çok rahatlamama hali vardı.

İrem's statement below illustrated that it is not enough to be told by physicians that nothing is wrong, yet she was in the need of an explanation for her unique experiences. Thus, she could not accept common explanations.

> I like self-confident talk (talking about doctors), but I had a doctor like that, whom I didn't like because he would just talk (confidently) to brush over. (What I liked was that) it wasn't "Nothing will happen, trust in yourself.", but he would genuinely explain "Look, this thing on your breast is this kind of cyst and is seen like this in people your age." and "It's scientific thing is this and that, but it's normal for you to be afraid." I mean, I like people who are self-confident with a more humane approach. However, "Nothing will happen with this, 9 out of 10 women have this." and stuff like that. I can't with that type, I change it because no, I don't believe those words and it seems like something has been overlooked.
>
> *Kendinden güvenli konuşmayı seviyorum (doktorlar için söylüyor), ama öyle bir doktorum vardı onu sevmemiştim çünkü o bir şey yani geçiştirmek için (güvenli konuşuyordu). (Benim sevdiğim) "Kendine güven bundan bir şey olmaz ya." falan gibi bir şey değil; hakikaten açıklıyor bana "Bak, yani bu memendeki şöyle bir kisttir, bu senin yaşındaki kişilerde şöyle görülür, işte bunun şudur budur bilimsel şeyi ama korkman normal." Yani böyle daha insani bir şekilde kendinden güvenli tiplere güveniyorum. Ama yani "Bundan bir şey olmaz, bak kaç tane dokuz kadından işte 10'unda var." falan daha. O tarzı hiç şey yapmam, değiştiririm yani, yok inanmıyorum yani onun sözüne bir şeyi gözden kaçırdı gibi geliyor.*

In fact, from time to time expectations from physicians were too intimate to be demanded. During the interviews, some participants expressed their demands from health care professionals, including the researcher. Fadime, for example, made a request to the researcher about taking her to the physician and explaining her troubles on her behalf. In this way, she thought she would be better understood by the physicians.

> What I expect from you now is to take me to a doctor, have my blood sample taken (laughing). Is my blood sugar high, is it due to psychologist (psychologic reasons) or due to sugar? So, what is the reason for this stinging in my hands? In short, my morale, because you are beside me, my morale will be high. The doctor, for example, won't see me like a peasant and look down on me because you are with me and you are educated. You, for example, "my mother, sister, or relative has this illness" and the doctor won't think of ignoring me, the doctor should care about me, should care about me really nice and well.
>
> *Senden ben şimdi ney bekliyorum beni götür doktora, kanımı aldır (gülüyor). Şeker mi var psikologtan (psikolojk nedenlerden) mı ileri geliyor şekerden mi? Şu ellerimin sızısı neyden ileri geliyormuş haydi. Yani moralim, seni, yanımda olacaksın ya moralim yüksek olacak. Doktor mesela beni şimdi köylü görüp de küçük görmesin, sen tahsillisin ya. Sen beni, mesela, benim veya annem bacım akrabam, bunun bu hastalığı var, önemsemez gibi düşünmesin doktor, önemsesin beni iyice güzel bir önemsesin.*

She also explained that physicians did not put herself at ease by saying that she did not have cancer when she had problems with a skin pimple. Similarly, she complained that her husband did nothing to clarify her condition and did not calm her down.

> (Physicians) Didn't say to me "If what you had were cancer, if you had cancer…" Or examine me and say "You are not cancer, don't be afraid, it will hurt…" or "it hurts due to psychologist, don't be afraid". I couldn't relax, to such extent that I was psychologistically depressed, so much so that I was left pain.
>
> See, just as I complain about the doctors, I complain about my husband. For example, not once did he tell me, because first Allah, then your wife, right? Your bedmate, your life mate. For example, whenever I can't sleep, he doesn't get up and comfort me. He doesn't say things like "What will happen to you, come let's take you to the doctor and get you better", then, "Don't worry about it, hopefully it's nothing." and he doesn't take me to the doctor... Not because he doesn't love me, he loves me, the mother of his children, loves me and respects me very deep down, I know. But there is this cluelessness.
>
> *(Doktorlar) bana demediler ki "Sen sendeki bu kanser olaydı, sende kanser olaydı…" İnceleyip de bir bakıp da "Kanser değilsin, hiç korkma, bu acıyacak…" veya "Psikologtan acıyor, hiç korkma." diye. Bir rahatlamadım, o kadar ki psikologum bozuldu, o kadar ki acıların içinde kaldım.*
>
> *Bak aynı doktorlardan şikâyetçi olduğum gibi eşimden de şikâyetçiyim. Eşim mesela bana demedi ki, önce Allah sonra eşin değil mi, yatak arkadaşın, hayat arkadaşın. Mesela ben uyuyamadığım zaman kalkıp bana bir rahatlık vermez. "Halin nice olacak böyle, gel seni doktora götüreyim de bir aydınlaştırayım, ondan sonra "Kafana sıkıntı etme, inşallah bir şey yoktur." deyip de beni bir doktora götürüp beni mesela… Yani beni sevmediğinden değil beni, beni seviyor tamam, çocuklarımın anası seviyor, sayıyor çok içinden gelerekten biliyorum. Ama bir fikirsizlik var.*

During the interviews, their expression styles used for reflecting their worries and health problems revealed another important point. Some participants used expressions such as "rest assured that", "do not suppose that I am exaggerating", "really".

Fadime used such expressions while explaining how her pain did not stop after the pimple on her leg was removed.

> (…) So much so that I was left writhing in pain. **Don't assume that I'm exaggerating,** it wasn't the kind of pain that I could patiently wait out. I got some cream and applied that cream, that cream, that cream with hot water and couldn't make the pain go away.

(…) O kadar ki acıların içinde kaldım. ***İnan abartıyor diye düşünme****, sabredecek şekilde acımıyordu ki. Krem aldım, o kremi, o kremi, o kremi sıcak suyla pansuman yaptım geçiremedim.*

Melek used "rest assured that" phrase while she was describing her health problems when she got sad.

I have lots of pain, my eyes burn, the inside of my head burns. There is this weariness. My brain hurts as if it is going to pop out. Sometimes I put ice, and sometimes I take a bath. In short, when that begins, **believe me**, it lasts a month. It lasts a month, sometimes 1.5 months.

Çok ağrılarım oluyor, gözlerim yanıyo, başımın içi yanıyor öyle yani. Böyle halsizlik oluyor çok. Beynim çıkacak gibi ağrıyor. Buz koyuyorum bazen, bazen işte şey banyo yapıyorum. Yani o bir başlayınca ***inan ki*** *annecim bir ay, bir ay sürüyor. Bazen 1,5 ay sürüyor.*

In a similar way, while expressing her fear to become paralyzed, Beren said that "It's as if I'm going to be paralyzed, *really* I'm not **exaggerating***,* you know, it just came to my mind, what if I get paralyzed, what will I do when I get paralyzed *("Sanki felç olacakmışım gibi gerçekten size* ***abartmıyorum*** *hani böyle aklıma geldi, ya felç olursam felç olursam naparım.")*.

Battologizing a word (repeating words) was another expression style that was thought to be related with the communication style mentioned above. Öykü repeated the word "arttı/increased" six times in a row when she was explaining how negatively she was affected by a traffic accident and subsequent health problems.

How should I say this, I mean, the stress I suffered within 4 years gradually **increased increased increased increased increased increased**. You know, while that increased, I started having some blood pressure problems. My blood pressure drops and I may have some dizziness and stuff.

Nasıl desem yani, 4 yıl içinde yaşadığım stres giderek ***arttı arttı arttı arttı arttı arttı.*** *Hani o artarken işte biraz tansiyon problemi de yaşamaya başladım. Tansiyonum düşüyor işte baş dönmesi falan biraz olabiliyor falan.*

Fadime also repeated some words while describing the pain she feels in her hand.

(...) The pain I have here, when it hits I **wander wander wander wander wander wander wander**. **I can't help it, can't help it**, it hits and goes crazy, then it goes away and I say it's better, I say it has passed.

(…) Buramın acısı gibi girdi mi ***geziniyoom geziniyom geziniyom geziniyom geziniyom geziniyom geziniyom. Napiyim napiyim****, bir oluyo çıldırıyor, bi oluyo geçiyor, iyi diyom geçti diyom.*

In addition to the verbal expressions, her behavioral demonstrations in the interview room were remarkable. During the interview, for example, she stood up and moved around to demonstrate how she climbed the walls when she was in pain.

It was thought that the purpose of this communication style was to stress the trueness of their symptoms, to convince others how difficult to live with them, and to make a call to others. Doctors appeared to be at the head of whom they call to make sense of what is wrong with them.

Moreover, it was seen that words such as "şey, yani, hani" (well, I mean, you know" were frequently used by the participants. For example, Öykü said:

> Now, I had just started to ride a bike and these dogs chased me. I fell a lot while riding alone. So, my father started to come with me, I ride the bike and he looks around and stuff (laughing). **It's like**, umm, he's nice and that was nice. Of course, now he is retired so he has more time.
>
> *Şimdi yeni yeni bisiklet sürmeye başladım işte şey oldu köpekler kovaladı falan. Baya düştüm falan tek başıma bisiklet sürerken. Mesela artık babam benimle birlikte geliyor, ben bisiklet sürüyorum o bakınıyor falan (gülüyor).* ***Hani şey yani*** *ıı iyidir o, yani güzel oldu şimdi. Tabi emekli oldu daha çok vakti var da.*

Frequent use of these words could be considered as a reflection of the feeling that they cannot express themselves adequately and as an effort to better explain themselves.

3.2.4. Every Cloud Has a Silver Lining: Benefits of Being/Feeling Ill

Almost all participants talked about the benefits of being/feeling ill in spite of the accompanying costs. While some gains were explicitly emphasized by the participants, others were deduced from the participants' accounts.

The first observed benefit was receiving attention or care. The source of care and attention can be children, parents, partners, or physicians. Melek did not clearly say any current positive side of being ill and even she emphasized how she was ignored by her husband. She thought that her husband does not show enough interest in her. She stated that when she did not

believe in the doctor who said nothing is wrong with her, her husband said “I took you to the professors and I do not know what else can I do?” and got angry with her. Although her husband was indifferent to and angry with her, her children cared for her when she felt unwell.

> I go, for example, you know, I am a patient and have complaint somewhere, so I go and lie down inside. He (husband) doesn’t even come near me, see he doesn’t even come near me. My son is very sensitive like me, so he comes ten times and paces about asking “Mommy, what do you need? Should I bring you this or that?” The daughter comes “Should I do this or that?”
>
> *Ben gidiyorum misal olur ya hastayım bir yerim rahatsızlaştım gidiyorum içeri yatıyorum. O (eşi) hiç yanıma bile gelmiyor, bak sen yanıma bile gelmiyor. Oğlum da benim gibi çok hassas, o geliyor on kere dolanıyor, “Anneciğim ne istersin şunu getireyim, bunu götürüyüm”. Kız geliyor “Onu yapayım bunu yapayım.”*

Moreover, while Melek was talking about her childhood, she stated how his father cared for them even when they had a little health problem. She added that she might be looking for such a care she received from her father.

> (…) My father was also very emotional. He was a very forward thinking, educated, and affectionate person. If one of us got sick or the slightest thing happen, he would carry us on his back and take us to the doctor. He would take care of us (herself and her siblings). Maybe I have been seeking those all these years. Think about it, you are smarter than me.
>
> *(…) Babam da çok duygusaldı. Çok böyle ilerici, çok aydın ve çok sevecen bir insandı. Biz de bir hasta olsa, ufacık bir şey olsa sırtına alır doktora götürürdü. Bizimle (kardeşleri ve kendisiyle) ilgilenirdi. Belki onları mı ben aradım anneciğim yıllardır. Düşün sen, benden daha zekisin.*

When talking about the physician from who she benefits most, Melek explained that she soothed her like a child.

> Anyway, later we went back to Dr. Ö, and this doctor, **as if consoling a child**, opened this arm of mine with slow movements and sticking tape here and there, because my arm wouldn’t open.
>
> *Neyse sonra geri Ö. hocaya gittik, o da beni böyle sanki **bir çocuk avutur gibi** yavaş yavaş hareket vererek, buralarıma bant yapıştırarak, bu kolumu açtı, açılmıyordu.*

Similarly, Fadime told that her children were fussing over her in the belief that she would die *(“Benim iki çocuğum benim gözüme bakıyor annem ölecek filan diye.”)*, although she

described her husband as inconsiderate *("Eş olaraktan beni bir doktora götürüp de önemsemiyor yani o kadar ki fikirsiz.")*.

The source of attention and care was her parents for Sevil. When Sevil was born, her father did not want her at home for a reason she did not know. Therefore, she started to live with her grandparents. After the cyst occurred in her ovaries, she went back to the home where her parents and her sister was living. That is, a health problem contributed to her return when she was 17 years old. When she was asked how her parents would treat her if she was sick, she said:

> They would probably treat me as if I was going to die. That's how well they would treat me… You know, I think, I think I don't want to be sick because I don't want to see this. For one, he would straight up make me quit being a vegetarian (taling about her father). (...) Besides, even now that topic comes up with my father at every dinner, but if that kind of situation were to happen (illness), I'm quite certain he would make me eat meat. My mother would also be very apprehensive, I'm sure of that, and even if I heal, it feels like I could never go back to my old life. Like, for example, graduating on my own, doing masters, and such. You know, I feel like I could never move into my own home. As if my parents would still be afraid of something, as if they would constantly have to protect me. For example, my aunt, like I said, went through this illness (cancer) 4 times, and still goes through it. Even in those periods when she was well, when we assumed that she was well, my mother would visit her every day, bring food to her, call her to ask if she ate. The same would happen to me.
>
> *Herhalde ölecekmişim gibi davranırlar o kadar iyi davranırlar. Hani böyle şey… Ben sanırım zaten bunu görmek istemediğim için hasta olmak istemiyorum. Şey işte, bir kere vejeteryanlığı direk bana bıraktırır (babası için söylüyor). (…) Zaten şu an bile her yemekte onun bi konusu geçiyor mutlaka babamla, ama öyle şey öyle bir durum olursa (hastalık durumu) eminim yani, bana şey et yedireceğinden. Annemler de çok evhamlı olurlar. Ona eminim ve sanki iyileşsem bile hiçbir şekilde eski hayatıma dönemezmişim gibi. Kendi başıma, mesela mezun olayım, yüksek yapayım falan. Hani hiçbir şekilde kendi evime çıkamazmışım gibi hissediyorum. Annemler hala bir şeylerden korkarmış gibi, beni sürekli bir korumak zorundalarmış gibi. Mesela teyzem diyorum ya 4 defa geçirdi bu hastalığı (kanser), hala da geçiriyor. İyi olduğu dönemlerde, iyileşti dediğimiz zamanlarda bile her gün annem teyzemin yanına gider, mesela her gün ona yemek götürür, arar yemeğini yedin mi diye sorar teyzeme. Bana da öyle olur.*

As seen in the extracts, she explained that if she got sick, she would be treated very well by her parents, although she complained about losing her independence. However, receiving care especially from her father seems to be important for her. The following quotation illustrated that she needs her father to show interest in her.

> For example, my father never says words of affection to me. He shouldn't either. I don't really expect anything after all this time. However, I wish I hadn't heard him say them to my sister or, for example, my sister comes home in the evening and he asks what she did and how she is. But with me, nothing.

Yani mesela babam bana hiçbir şekilde sevgi sözcükleri kullanmaz. Kullanmasın da zaten. Hani bu saatten sonra gerçekten hiçbir şekilde beklemiyorum. Ama ablama kullandığını da keşke duymasaydım ya da mesela ablam akşam eve geliyor nasılsın naptın bugün halini hatırını soruyor. Ama benim yok.

As it can be seen in the penultimate extract, the association between illness and getting care and attention was observed by Sevil when her aunt was ill. In another example, Öykü stated that her mother and her father were a little bit irresponsible and negligent people: 'My mother, I mean, I can say she is a bit irresponsible and negligent (laughing). I mean, look, two irresponsible people have come together." *("Annem yani o da biraz sorumsuz ve ihmalkâr diyebilirim (gülüyor). Ya şey iki sorumsuz bir araya gelmişler.")* In contrast to this description, she stated that her mother spoiled her little brother: 'My mother somehow really spoils my little brother." *("Annem bir şekilde kardeşimi çok şımartıyor.")* When she was talking about her childhood, she explained that she acted on her own and her mother was more interested in her brother because he was junior and he had an illness, temporary epilepsy, due to a fall.

(…) In those days my mother was working, so she was not at home for a certain part of the day. I was studying so was not available. You see, I used to take a course on the weekdays or, you know, when I was smaller, during middle school, I would just say "I'm going outside" and leave the house and go for a walk at the park or in Tunalı, but we used to live in Kurtuluş. I wouldn't spend a lot of time at home. I think I liked being outside. My mother wouldn't say anything, or perhaps she didn't care I don't know (laughing). My brother was of course very small at the time; she would take care of him more. (Brother) He also had an illness, had temporary epilepsy and stuff. (...) That's why she might have paid more attention to him.

(…) O zamanlar annem çalışıyor zaten günün belli bir kısmında evde yok. İşte ben okuyorum, yokum. İşte hafta içleri ya bir kursa gidiyorum ya da hani çok küçük yaşlardayken ben işte mesela ortaokula giderken falan "ben çıkıyorum" deyip evden çıkıp işte parka yürüyüşe ya da işte Tunalı'ya kadar yürüyüşe gidebiliyordum ama Kurtuluş'ta oturuyorduk yani. Öyle şey evde çok vakit geçirmiyordum. Galiba dışarıda olmayı seviyordum. Annem de bir şey demiyordu ya da işine mi geliyordu bilmiyorum (gülüyor). Çok şeydi ya, kardeşim tabi o zaman daha küçüktü onla daha çok uğraşıyordu. (Kardeşi) Ya bir de bir hastalık geçirdi geçici epilepsi oldu falan. (…) Biraz daha ilgilenmiş olabilir bu sebeple.

She explained that her physical activities were restricted due to a small fracture in her hipbone. For instance, she had difficulty in riding bicycle that was one of her favorite activities. Due to this disability, however, her father helped her, and, she could safely ride the bicycle.

Now, I had just started to ride a bike and these dogs chased me. I fell a lot while riding alone. So, my father started to come with me, I ride the bike and

he looks around and stuff (laughing). It's like, umm, he's nice and that was nice. Of course, now he is retired so he has more time.

Şimdi yeni yeni bisiklet sürmeye başladım işte şey oldu köpekler kovaladı falan. Baya düştüm falan tek başıma bisiklet sürerken. Mesela artık babam benimle birlikte geliyor, ben bisiklet sürüyorum o bakınıyor falan (gülüyor). Hani şey yani ıı iyidir o, yani güzel oldu şimdi. Tabi emekli oldu daha çok vakti var da.

Similar to Sevil, Melek, and Öykü, health problems occupied an important place in İrem's relationship with her father.

(...) I have a turbulent relationship with my father. Whenever these symptoms increase, I call my father first and ask him to take me to the doctor. I mean, even if we are cross with each other, I call my father and he really takes me to the doctor. Our dispute always has a tendency to end with this.

(…) Benim babamla çok çalkantılı bir ilişkim var. Bu sağlık semptomlarım arttığında da ilk babamı ararım ben, baba beni doktora götür diye. Yani küs olsak da babamı ararım, babam hakikaten beni doktora götürür falan. Öyle yani küslüklerimizin hep böyle bir bununla bitme eğilimi vardır.

Beren said that her boyfriend stood by her in the period of experiencing health problems related to genital herpes.

(...) During the period of this illness, genital herpes, I was already with him when going through this. In that period, in the period after that, during psychological treatment, he was the one, you know, how can I say this, the one that guided me. You know, "Let's do this or that if you want" and he was always with me while I was going to the doctors, while I was being treated.

(…) Bu hastalığım sürecinde, genital uçuk, zaten onun yanındaydım bunu geçirdiğimde. O süreçte, ondan sonraki süreçte, psikolojik tedavi sürecinde beni hep şey yapan, nasıl desem yönlendiren ve şey yapan taraftı. Hani "Şunu yapalım istersen, bunu yapalım istersen" diye ve doktorlara gitmem sürecinde, tedavi sürecinde hep yanımda oldu.

During the interviews, some participants stated that their health anxiety appeared when they had a problem with their relationships or job, and interestingly, their health condition improved right after the problems disappeared.

For example, when Onur was about 17 years old, he went to a doctor due to his sleep problems; too much sleeping and having trouble in waking up. According to the results of the blood tests, there was a significant abnormality indicating a problem in his immune system.

Physicians initially suspected from different health problems including AIDS, leukemia, lymphoma, and myelodysplastic syndrome, but after many examinations, these possibilities were excluded. They could not find the reason for the abnormalities and they decided that Onur had to go for a check every 6 months. According to his statements, his blood values were affected by his emotional state.

> (...) It's very related to my emotional state. For example, approximately 3 months ago, I have had this ex-girlfriend for quite some time, when I made amends with her, my values came out normal for the first time in 2.5 years.
>
> *(…) Duygusal durumumla çok alakalı. Mesela yaklaşık 3 ay önce bir dönem, çok uzun süredir eski sevgilim var, onunla barıştığımda 2,5 sene sonra ilk defa normal çıktı değerlerim.*

Likewise, İrem stated that her health anxiety increased in a period when she was worried about her relations at work.

> (…) I think around November I started to be worried about everything. Not just health anxiety, but also things like "Did I make a mistake here, will the teacher be angry, did I mistreat the students, what if they file a complaint about me..." I started being extremely obsessed with lots and lots of things. It's a simple urinary tract infection. After that, the health checkups began again and I had a serious attack there.
>
> *(…) Böyle bir Kasım gibi filan her şeye çok kaygılanmaya başladım. Sadece sağlık kaygısı değil, "Şurda yanlış mı yaptım, hoca kızacak mı, öğrencilere yanlış mı davrandım, ya beni şikâyet ederlerse…". Bir sürü, bir sürü şeyi böyle aşırı takmaya başladım. O basit bir idrar yolu enfeksiyonu. Ondan sonra yine sağlık kontrolleri başladı, yani çok ciddi bir atak geçirdim orda.*

These kinds of expressions of the participants made the researcher think about the reasons and the functions of such an increase in health anxiety. In this regard, Demet's following statements pointed out that health anxiety was could also be a mechanism for coping with other life difficulties.

> (…) I also had a phase of psychological blood pressure illness during this 2010-2013 period. This blood pressure I speak of would reach 20 or 19 when I was 20 years old. I would have hallucinations due to high blood pressure. There was no real reason for it. I used to work at a teaching institution back then. It got better when I quit.
>
> (…) Whenever I am upset or have a problem, this (health anxiety) shows up. I attribute it to this; I create another problem to survive the initial problem (laughing), in order to forget the other problem. This is what I attribute it to because I might go to the east for 6 years and I don't want to go. Umm, I'm looking for alternatives so that I won't have go.

(…) Bir de psikolojik bir tansiyon hastalığı sürecim oldu yine bu 2010-2013 sürecinde. Bu bahsettiğim tansiyonum benim 20 yaşındayken 20ler, 19lara çıkıyordu. Halüsinasyon görüyordum yüksek tansiyondan dolayı. Hiçbir sebebi yoktu. Dershanede çalışıyordum o zamanlar. İstifa ettim geçti.

(…) Ne zaman benim bir üzüntüm sıkıntım olsa, bu (sağlık kaygısı) ortaya çıkıyor. Ben şuna yoruyorum; o üzüntü sıkıntımla survive edebilmek için başka bir sıkıntı yaratıyorum kendime ki (gülüyor) öbürünü unutabileyim. Ben buna yoruyorum çünkü şu an benim doğuya gitme durumum var 6 yıl ve gitmiycem. Iıı ve gitmemek için başka alternatifler arıyorum burada.

Another benefit of being or feeling ill emerged as the rearrangement of duties and priorities and putting the health above everything else. As a consequence, participants experienced an increase in self-care, self-acceptance, and self-worth; and a decrease in guilt feelings.

Ali's greatest fear was being unable to work because of an illness and losing his reputation.

So, my greatest thing is this, since I am the only source of income for the family, I am providing my children education. My greatest fear is this, I mean, illness. I fear something might happen to me, I might leave my children in such a state... I also have a reputation in this environment. I mean, you know, when I contracted this illness, I couldn't work for 1 year.

Ya benim en büyük şeyim şu, ben ailenin tek geçim kaynağı olduğum için çocuklarımı okutuyorum. En büyük korkum şu, yani hastalık (ile ilgili) korkum; bana bir şey olursa, çocuklarımı bu durumda bırakırsam... Hani bir de çevreye karşı bir itibarım var yani. Böyle hani, ben bu hastalığa yakalandığımda 1 yıl çalışamadım.

However, he also underlined that he could take a rest and take care of himself when he feels sick.

Once a year it is an immense amount of stress. This illness comes suddenly and you forget everything else. Your head aches, your body aches, you literally lie down, *I* **lie down and rest**. (...) This illness turned into such a thing that *I* **take care of only myself***,* I mean, because I am the one who needs to be standing.

Yani şöyle yılda 1 kere aşırı derecede stres. Bu hastalık bir anda geliyor, bütün her şeyi unutuyorsun. Başın ağrıyor, gövden ağrıyor, hemen yatıyorsun, ***yatıp dinleniyorum.*** *(…) Bu hastalık öyle bir şey oldu ki* ***sırf kendimle ilgileniyorum****, yani sırf benim kendimin ayakta kalması lazım yani.*

After Melis was diagnosed with cancer and learned that it was a misdiagnosis, she started to do things that she had always wanted to do. Moreover, she added that her mother was reluctant to let her move into a separate apartment, but after these events she approved it.

> After this period, it didn't immediately happen. I didn't become extremely anxious. I was full of life and "I'll go to this training; I'll do this as well." In fact, I found myself in training sessions on psychotherapy application for cancer patients and such. Then I stopped. I realized that I was trying to cope. "Slow down a little". Then, I returned to masters. It was a little, for example, I moved out to my own home. Maybe that's why my mother gave me permission to move out immediately, I don't know. Maybe because my life was saved. Umm, I made some friends here and blew off the thesis. I said I'll extend it, you know, I don't care much. I lived through a fun period, in bars, without working. I mean, in those days I would say "Oh well, everyone can be this, we can die like this, and so on."
>
> *Sonra bu dönemden sonra, hemen de şey olmadı. Yani aşırılı kaygılı olmadım. Böyle aşırı hayat dolu bir şekilde, işte "O eğitime gidicem, bunu da yapıcam" diye. Böyle hatta kendimi şeyde buldum kanserli hastalara psikoterapi uygulamaları eğitiminde falan buldum bi. Sonra bıraktım, şeyi fark ettim yani başa çıkmaya çalışıyorum. "Bir dur". Ondan sonra yüksek lisansa döndüm. Şey oldu biraz, eve çıktım mesela. Annem hemen izin verdi belki de o yüzden eve çıkmama bilmiyorum. Hayatım kurtuldu diye. Iıı işte şey, arkadaş çevresi edindim burda ve saldım tezi. Dedim uzatcam yani dedim umurumda değil. Birazcık öyle şey bir dönem yaşadım; eğlenceli, barlarda, çalışmadan. Yani hemen o zamanlar böyle işte şey diyordum "Aman ya herkes şöyle olabilir, böyle ölebiliriz, bilmem ne."*

She also draws an analogy like that: "I may have turned from a person who was constantly saving money to someone who is spending money for enjoyment with the thought that anything can happen at any time." *("Sürekli para biriktiren bir insandan yani her an her şey olabilir şu an keyifli bir şey yapayım bu parayla diyebilen bir insana dönmüş olabilirim.")*

She described how things have changed for her as follows:

> (...) It was also as if I had come to my senses because I used to be a person that planned everything a lot. Ok, now I'm going to finish school, I'll do this, then I'll do that, then this this and this. That thing stopped, but in my opinion that was a good thing (laughing).
>
> *(…) Sarsılıp kendime gelmişim gibi de oldu çünkü her şeyi böyle çok planlayan bir insandım. Tamam, işte okulu bitireceğim, bunu yapacağım, sonra bunu yapacağım, sonra şu şu şu diye. O şey bozuldu, ama iyi oldu bence (gülüyor).*

Besides, she stated that after her experiences, she accepted herself just the way she is.

> Before this situation, I used to worry too much about certain things. My nose is big, or my hands are chubby, I don't know, I hate my feet they are too ugly and stuff. I didn't really like myself and wouldn't look at my photos. After this situation, I began to accept this a lot. I mean, thoughts like "This is good, all right, this is what I am, fine, I'm not a model" came into being. I wasn't bothered with it. For example, in a period when I was worried about having pimples, I went to a doctor for them and it passed. I had a small treatment, and I'm a little bit more, you know, towards myself. For example, these days I have gained a lot of weight and I say it's fine, I'll buy larger pants and lose weight anyway. So, I have begun to love myself a little bit more after this situation. This was one benefit of this situation. Sometimes someone says "You appear really ugly." to one of my photographs and I really don't care because that's me. When you look at it now, you kind of see this. It's like there is a kind of acceptance, I don't know.
>
> *Bu durumdan önce ben bazı şeyleri çok kafama takardım. Benim burnum büyük, işte ellerim tombik, ne bileyim ayaklarımdan nefret ediyorum çok çirkinler falan. Baya da şey hani hiç kendimi beğenmezdim falan, fotoğraflarıma bakmazdım. Bu durumdan sonra bunu aşırı kabullendim. Yani hani "Çok güzel ya tamam ben böyleyim, tamam manken değilim" gibi bir şey geldi, Kafaya takmıyorum. Mesela sivilceliyim bilmem ne diye dert ettiğim dönemde de sivilce için doktora gittim, geçti. Mesela ufak bir tedavi gördüm, biraz daha şeyim kendime. Mesela şu aralar çok kilo aldım, tamam o zaman biraz daha büyük pantolon alırım falan diyip, zayıflarım nasıl olsa deyip biraz daha şey yapmaya başladım. Hani biraz daha kendimi sevmeye başladım bu durumdan sonra. Öyle de bir artısı oldu işte. Bazen biri "Fotoğrafta sen ne kadar çirkin çıkmışsın." falan dediği oluyor, gerçekten umurumda olmuyor çünkü o benim yani. Şu an bakınca da bunu görüyorsunuz gibi, böyle bir kabullenme geldi bilmiyorum.*

İrem noticed that she turns into a careless person when she feels bad and evaluated these moments as a "bad holiday". She explained that in case of an increase in health concerns, she did not feel obliged to do things that she had to do before.

> (…) I realize that when I excessively do the things I don't want to do, or, in fact, it looks like I want to do them, but when I do too many, these things seem like vacation to me. However, a horrible vacation, not a nice one, but I really don't care about anything. I mean, it's not like, my responsibilities, I mean I may not go to class, join meetings, I might hurt someone's feelings, may not answer phone calls, and I'm kind of, I mean, my condition right now is really bad. I have nothing to do. I really become a terribly indifferent person.
>
> *(…) Şeyi fark ediyorum yapmak istemediğim şeyleri çok yaptığım zaman, ya da aslında yapmak istiyorum gibi oluyor ama çok fazla şey yaptığım zaman, bu şeyler bana biraz tatil gibi geliyor. Ama çok kötü bir tatil yani, güzel bir tatil değil, ama hakikaten hiçbir şeyi umursamıyorum. Yani şey gibi değil, sorumluluklarımı, yani derse gelmeyebilirim, toplantılara gitmeyebilirim, birini kırabilirim, telefonları açmayabilirim ve hani şeyim yani şu an benim durumum çok kötü. Yapacak hiçbir şeyim yok yani. Hakikaten müthiş umursamaz bir insan oluyorum yani.*

Duru explained that her mother and father decided to bring her into the world so that she could be a support to her sister.

> When I was born, I was born with a purpose. I am an individual that was born so she wouldn't be alone, and this wasn't hidden from me. So that there could be a sibling to support my sister, so that we could support each other, to be companions for life even our parents are gone, so that we could have sisters. (During periods when her mother and father lost their own mothers) They were left alone when they lost their mothers. I was born after that, they decided on me after that. There is an 8-year difference between me and my sister. I mean, they weren't even thinking about having another. I am already a later child for this family. That is why I was made. That is my purpose. Later, when my sister started having minor psychological problems, my purpose was to watch her, to observe her, and, if necessary, try to keep her under control. That's the kind of life I had anyway.
>
> *Ben zaten doğarken bir amaçla doğmuşum. Ben o yalnız kalmasın diye doğmuş bir bireyim yani ben ve bu benden gizlenmedi yani. Ablama destek olacak bir kardeşi olsun, birbirlerine destek olsunlar, biz olmasak bile bir hayat arkadaşları olsun, hani bir kardeşleri olsun diye. (Anne ve babası kendi annelerini kaybettikleri süreçte) Yalnız kalmışlar annelerini kaybetme süreçlerinde çok. Ben ondan sonra dünyaya geldim, bana ondan sonra karar vermişler. Benim ablamla aramda 8 yaş fark var. Zaten hani hiç yapmayı düşünmüyorlarmış, zaten geç bir çocuğum zaten ben aileye göre. Ben ondan olmuşum, oluş amacım o. Daha sonra ablamın ufak tefek psikolojik problemleri çıktığında da benim amacım ablamı gözetlemekti gözlemlemekti onu yeri geldiğinde kontrol etmeye çalışmaktı. Böyle böyle bir hayatım oldu zaten benim.*

She explained how she continued to fill this role assigned to her by her parents by helping people being in a difficult situation.

> I'll go the distance for people who are in a bad situation, I will. When they are sick, I will do to their home and seriously do their cooking, cleaning, and other specific stuff. I'll do these even if they don't want it because I know they can't do it. I'll do anything they need. (...) I even did it to a friend of mine whom I wasn't very close with. Or, for example, what happened most recently was a friend of mine opened a nursery and this friend lost their father. The nursery needed to be taken care of by someone. So, I dropped all the things I had to do, and I had a serious job which I simply walked away from. Thus, I managed the nursery and then returned. I mean, in these situations I just leave what I have and do these. In fact, this was also something I did in the family. I mean, I don't do anything contrary. I still do it. For example, someone is going to give birth and wants me beside them. Even if this is someone irrelevant. This also happened. I mean, we weren't really close friends, but I went there anyway. During birth this person said "You can come in" and I just went in, and I'm afraid of blood. (…) When I do that, I feel complete. That is the problem. I feel really complete because I'm doing something I know. It feels like I'm doing something that I am obligated to do.

Zor duruma düşen insana yani fizana giderim, giderim yani. Hasta olduğunda evine gidip ciddi anlamda yemeğini, temizliğini ve belirli şeylerini yaparım. İstemesse de yaparım yani çünkü biliyorum onu yapamayacak. İstediği başka bir şey varsa yaparım. (…) Çok yakın olmayan bir arkadaşıma bile yapmışlığım var bunu. Veyahut en son şey oldu mesela bir arkadaşım kreş açtı, babası vefat etmişti. Kreşin birisi tarafından şey yapılması gerekiyordu. Bütün işimi bıraktım burda ki ciddi bir işim vardı çektim gittim. Kreşi yönettim, geri döndüm yani. Hani böyle durumlarda şey yaparım, kendi işimi bırakıp yaparım. Aslında bu ailede de yaptığım bir şeydi benim. Yani tersine bir şey yapmıyorum. Hala yaparım. Mesela atıyorum birisi doğum yapacak, ben yanında olayım istiyor. Alakasız da birisi. Bu da oldu. Hani çok yakın da bir arkadaşım değil, atladım doğumuna gittim. Doğumda "İçeri sen gir" dedi atladım içeri girdim ki ben kandan korkarım. (…) Onu yaptığımda tamamlanmış hissediyorum sorun orda. Gerçekten tamamlanmış hissediyorum çünkü bildiğim bir şeyi yapıyorum. Yapmam gereken şeyi yapıyorum gibi hissediyorum.

On the other hand, she also explained how she began to protect herself from over-demanding individuals with the help of her health anxiety.

I do that frequently as well. At 4 or 5 in the night, for example, a friend of mine calls. I mean, normally I'm a bit, you know, the last technique I used in these illnesses and stuff was to make people think I am unstable. For instance, I'm really happy with this because when people think I am unstable they may not be too demanding. You know, to protect myself. I am aggressive when necessary, unstable when needed. Yes, I have anxiety as well. I can't do this because I have anxiety. In fact, I recently started using this. So, I don't stress about other stuff as I used to because, like I said, I tell people I'm open. I don't really care about what people are going to say. I'm trying to live in the moment from now on.

Onu da çok sık yapıyorum yani. Gecenin 4'ünde 5'inde mesela bir arkadaşım arar. Yani normalde şeyimdir de, hani en son yaptığım teknik mesela bu hastalıklarda da şeylerde de beni insanlar dengesiz bilsin. Mesela ben bundan çok mutluyum çünkü dengesiz bildiklerinde çok fazla demanding olmayabiliyorlar. Hani kendimi korumak için. Yeri geldiğinde agresfim, yeri geldiğinde dengesizim. Evet, anksiyetem de var. Bu işi yapamıyorum çünkü anskiyetem var. Aslında bunu kullanmaya da yeni yeni başladım. Onun için de eskisi gibi stres yapmıyorum başka şeyleri, çünkü dedim ya açığım diye söylüyorum. İnsanların ne diyeceği pek de umrumda değil. Anı yaşamaya çalışıcam artık.

Relief from guilt was another consequence of relief from responsibilities due to a health condition. Demet mentioned that since she did not fulfill her responsibilities, she feels guilty, but at the same time, she also feels herself free from this guilt, because her diagnosis legitimizes her irresponsibleness.

(…) For example, I'll blame myself if I were sick, if I were cancer, if I went crawling. Because I would have forced my mother and father, my aged mother

and father, and my brothers to take care of me, because I bound them to myself. For example, (family member/s taking care of her) being able to (corrects herself) not being able to go out to the street, I would feel guilt for this. However, if it were the apocalypse due to a higher power, I'm not a believer, but if it were the end of the world, it would somehow be nobody's fault. It happened, it's a natural disaster, excellent.

D: There were a lot of times when I felt guilt.

Researcher: About what?

D: I could have been more successful. I mean, I could have worked harder and studied in a better field; but then I'd say "All right, I'm dyslexic and couldn't have done it even if I wanted to." A relief came over me when I got the diagnosis. So, I escaped my feelings of guilt when I got diagnosed with dyslexia.

Researcher: You escaped with the diagnosis.

D: I would constantly blame myself by saying "I could have worked harder, been better, I wouldn't have disappointed my family and my brother." But when I got that diagnosis, it passed. I don't have any feelings of guilt right now.

(…) Mesela hasta olsam, kanser olsam, sürünerek gitsem kendimi suçluycam. Annemi, babamı, yaşlı annemi, babamı, abilerimi bana bakmaya muhtaç ettiğim için, onları kendime bağlı kıldığım (için). (Kendisinin bakımını üstlenen aile üyesi/üyeleri) Mesela bir sokağa çıkacak (düzeltiyor) çıkamayacak bunun için suçluluk duyucam. Ama kıyamet kopsa, bir güç tarafından, inançlı değilim ama dünyanın sonu gelse bir şekil, kimsenin suçu değil ki. Gelmiş işte doğa olayı, mis gibi.

D: Suçlu hissettiğim çok oldu.

Araştırmacı: Hangi konuda?

D: Daha başarılı olabilirdin dedim. Yani daha çok çalışıp çok daha iyi bir bölüm okuyabilirdim ama sonra "Ha tamam disleksiymişim ben ya, zaten istesem de yapamıyormuşum." deyip bir rahatlama geldi o tanıyı aldığımda. O yüzden o suçluluk duygumdan disleksi tanısı alınca kurtuldum.

Araştırmacı: Tanıyla kurtuldunuz.

D: Sürekli "Daha çok çalışabilirdim, daha iyisi olabilirdim" diye sürekli kendimi suçluyordum. "Aileme, abime hayal kırıklığı yaşatmayabilirdim." diyordum ama o tanıyı alınca geçti. Şu an herhangi bir suçluluk duygum yok.

As regard to guilt, Duru told she feels guilty if she thinks that the underlying cause of her problems was related to her psychological state rather than physiological reasons. As a matter of fact, simply because of this, her boyfriend asserted that the reason for her problems could be biological just to relax her. From the following statements, it can be inferred that having a physiological illness has a guilt-eliminating effect.

> I am aware it's psychological, but maybe it isn't, I don't know. I was talking about that with my boyfriend. He says "It could also be a biological problem, you pull yourself together saying it's psychological." because when I go saying it's psychological, I feel ashamed. I feel ashamed with myself and feel guilt. My boyfriend is trying to suggest that it could be a bit more biological and it could resolve itself. He says "Don't be so hard on yourself by saying it's psychological. Maybe it's biological and we can overcome this with smaller things."
>
> *Psikolojik olduğunun da farkındayım, ama belki de değil bilmiyorum yani. Erkek arkadaşımla onu konuşuyorum. O diyor ki "Biyolojik bir sıkıntın da olabilir, sen psikolojik diye çok hani kendine geliyorsun.", çünkü psikolojik diye gittiğimde çok utanıyorum. Kendi kendime çok utanıyorum ve çok suçlu hissediyorum kendimi. Erkek arkadaşım birazcık daha biyolojik olabileceğini ve kendi kendine halledilebileceğini yönünde daha farklı bir telkin vermeye çalışıyor. "Bu kadar çok psikolojik diye de kendine yüklenme, belki de biyolojik hani küçük şeylerle bunların üstesinden gelebiliriz" diyor.*

In conclusion, as discussed in this theme, participants stated that receiving attention and care, using health anxiety as a defense mechanism to cope with other problems, and gaining the right to exemption from responsibilities and putting health above all else were the positive sides of being ill or feeling ill besides the negative aspects.

CHAPTER 4

DISCUSSION

This study attempts to understand how health anxious individuals, also known as hypochondriacs, evaluate their complaints, what their experiences related to health issues are, and how they interact with health care professionals and with the individuals close to them. For this purpose, the participants were interviewed and the collected data were analyzed through interpretative phenomenological analysis and as a result, four themes emerged: 'Causal attributions of health anxiety: Loss at the core as an unfinished business', 'Being drawn into the vortex of the symptom', 'An endless call to an expert for naming own experiences and eliminating uncertainty', and 'Every cloud has a silver lining: Benefits of being/feeling ill'. These themes will be discussed in the following sections.

4.1. Causal Attributions of Health Anxiety: Loss at the Core as an Unfinished Business

Regarding the emergence of their health anxiety, most of the participants stated that they had a predisposition to be anxious, that at least one of their parents was anxious, and experienced an event that caused them to focus on their health. The participants attributed the causes of health concerns to the combination of those factors rather than one of them, and this seemed to support the diathesis-stress model. This model suggested that the accumulation or coexistence of vulnerability, which is the "diathesis" part of the model, and stressful experiences lies behind psychiatric disorders (Russo, Vitaliano, Brewer, Katon, & Becker, 1995).

Almost all participants stated that they had at least one anxious parental figure at home. This information conformed to the perspective of attachment theory which suggests children form a set of representations of relationships based upon their experiences with parents (Bowlby, 1969). That means, for health anxious individuals, anxious attachment style appeared to be dominant and it has been transmitted from one generation to the other. From a different perspective, identification with parents who spoke too much about physical complaints and illnesses, as Wahl (1963) explained, could be another explanation behind an anxious parent-anxious child pattern. According to the interviews, an anxious parent in the family appears to have two opposite effects on children: a very anxious child or a very insensitive child. When the participants were asked how their siblings behaved in health-related matters, they said

that their sisters or brothers were either very worried even if not particularly in about health or not concerned about the illnesses at all. The mechanism behind this finding could be explained by the mechanism of reaction formation. Similar to counterphobias, the indifferent attitude might be a kind of defense mechanism against anxiety. In reaction formations, the anxiety does not disappear and the opposite attitude, in this case, a predisposition towards anxiety still exists in the unconscious (Fenichel, 2005). In the interviews, there was no evidence that anxiety was somehow in the background of those siblings, most probably since one-to-one interviews were not conducted with those siblings, and the conditions required for the emergence of anxiety may not have occurred for those individuals.

Moreover, as explained in the results section of the study, participants addressed that there were unresolved loss issues and that seems to have the central role. Losing life was one of the aspects of the loss. Some participants reported that they associated their fear of illnesses with fear of death. As in the case of Ali, some participants stated that fear of death emerged after experiencing an illness, and some even stated that death fears had preceded their health concerns. The literature supported the link between fear from illnesses and fear of death. A meta-analysis showed a positive association between death anxiety and hypochondriasis (Stegge, Tak, Rosmalen, & Voshaar, 2018). The fear of death was argued as a basic fear underlying the development, course, and continuity of the hypochondria by several approaches such as terror management perspective or cognitive-behavioural approach (Arndt, Routledge, Cox, & Goldenberg, 2005; Furer & Walker, 2008; Strachan et al., 2007). Some participants' health concerns were focused on the reproductive areas such as the breast, ovary, or genital area. Considering that people who are anxious about their health are also afraid of dying, their concentration on these body parts can be explained by the concept of “symbolic immortality”. The concept of symbolic immortality was described by Lifton (1979) as people having difficulty in accepting the fact of death at the level of consciousness and therefore tending to suppress it. However, every person knows that death is inevitable. This knowledge that life is finite creates a need to develop a sense of continuity in the person, and this need is described as a need for a sense of symbolic immortality. One way of achieving symbolic immortality that allows people to confront their mortality is biological mode. The biological mode describes the situation in which a person copes with his/her mortality by ensuring the continuity of his/her generation through reproduction (as cited in Florian & Mikulincer, 1998). Therefore, the focus of participants' anxiety on the breast or genital areas may be related to the difficulty in coping with the idea of death, and at the same time the idea that the biological mode providing symbolic immortality will be damaged.

The psychoanalytic perspective also suggests that fear of death was an important part of hypochondriasis. According to Wahl (1963), hypochondria is a defense mechanism against fear of death. He associated the protective characteristics of illnesses with intense aggressive death wishes of children towards a parental figure. Given the fact that such aggressive wishes are mostly unconscious, and the interviews conducted within the scope of the research are limited, it may be natural that there is nothing to confirm this information about the function and mechanism of the fear of death.

The mentioned loss contains not only the loss of life and loss of health domains but also separation issues. Looking at what the illnesses and losing health meant for the participants, it was seen that they associated losing health with losing power, reputation, independence, life, and loved ones. Fear of illnesses, fear of death, and fear of separation seem to be intertwined while explaining their health anxiety. It has been shown in the studies that illness anxiety feeds death anxiety and death anxiety increases illness anxiety. Thus, the causality between them is not clear (Stegge, Tak, Rosmalen, & Voshaar, 2018). As a result, what is important here is the relationship that one establishes with loss. Considering the statements of the participants, fear of losing one's life, health, or the relationship might be the reflection of not knowing how to manage loss including death, illness, or separation. In other words, hypochondria and the accompanying fear of separation and death may be a reflection of the inability to handle the idea of loss. Supporting this view, Freud explained that the death fear originated from the feeling of not being able to cope with danger and there are no protecting forces. Thus, the integrity of the corporeal ego has been threatened (Wilton, 2003).

4.2. Being Drawn into the Vortex of the Symptom & An Endless Call to an Expert for Naming Own Experiences and Eliminating Uncertainty

The health-related career choice of the participants and their thoughts and behaviors shaped around their health anxiety indicate the central position of the health anxiety in their lives. Such preoccupation is emphasized as an important feature of hypochondriasis in many different theoretical approaches; it is even included in the definition of hypochondriasis (Baur, 1989). The statements of participants showed that the most important reason for getting within the symptom more was the effort to gain control over it. Being knowledgeable about symptoms and treatment of illnesses, taking care for health to prevent illnesses, thinking about bad things that might happen in the future and getting prepared for them in advance by doing so, and being close to the hospitals where physicians can help them were important parts of trying to get control.

Nevertheless, the participants stated that having more information about their symptoms and trying to control their health status had a two-way effect, that is, both anxiety-reducing and anxiety-enhancing. The anxiety-enhancing nature of searching symptoms on the Internet was supported by many studies in the literature (Baumgartner & Hartmann, 2011; Doherty-Torstrick, Walton, & Fallon, 2016), but there were also studies showing that this search provides a sense of control in addition to the anxiety-enhancing feature (Singh, Fox, & Brown, 2016) supporting the finding of the current study.

One of the reasons why people get even more into their symptoms in this way might be the enjoyment they get from these anxiety symptoms. As it was clearly stated by İrem, it seems that there is a point where the health anxious person enjoys the health-related work or health-related routine whether consciously aware or not.

Wahl (1963) mentioned that health anxious individuals give the impression that they are getting pleasure from being sick because they were mostly reactive to medications, and psychological and physiological explanations intensified their anxiety. In the interviews, participants emphasized their relationship with the physician while explaining how they react to the explanation made by the doctor and how they adhere to the treatments they were given. If the given treatment came from a doctor whose knowledge was not trusted, they either said that the given treatments had no effect or even had side effects, or that they did not comply with the given treatment at all and that they were looking for another doctor. Similarly, if the diagnosis was made by a doctor whom they do not trust, they have difficulty believing in the accuracy of the diagnosis as long as they do not have a diagnosis that causes them to be seriously concerned about their health such as cancer. However, even if the diagnosis and treatment came from a doctor whom they could trust, they feel relief for a while, and then somatic complaints seem to persist in other ways. For instance, Beren said that she was relieved when she was diagnosed with genital herpes, but after a while, she began to worry about what might happen in the future. It was observed that participants were relieved by the support they received from their parents or partners, or by physicians who met their “good physician” criteria and made a diagnosis or applied a treatment. However, this relaxation did not eliminate the health concerns of the participants. For Sevil, the relaxation time was very short, while for Gizem, anxiety was defined as peculiar to the current period. For İrem, on the other hand, anxiety was usually too weak to affect her, but rarely, it became very intense. Although the duration of anxiety or relaxation varies, each participant spoke of a cycle. Freud made a separation between anxiety and fear in terms of having an object or not; fear had a specific object, and anxiety had no object. However, Lacan said that anxiety had an object, and that was “object a” (Evans, 1996). The participants seem to seek information that will

somehow help them make sense of their experiences in their bodies; mainly a diagnosis. At that point, it is possible to think of the diagnosis as “object a”. Even though the person believes that when he reaches “object a”, s/he will find what s/he is looking for and feel complete, by nature it is something that constantly escapes (Burgess, 2017). As explained, when participants received a diagnosis, they were relieved for a short time or felt that it was not true. The shortness of the relaxing effect of the diagnosis and the ideas about the inaccuracy of the diagnosis suggested that the diagnosis could be “object a” for people with health anxiety.

It was also observed that when participants received a diagnosis and they believed the accuracy of the diagnosis, they were not worried at first because they focused on how they could deal with this “real” situation. Their concerns reappeared after they learned that the diagnosis was wrong or after they started to receive treatment in relation to their diagnosis and experienced another somatic complaint. This situation exemplifies that anxiety is closely related to expectation; the expectation of a danger (Freud, 1926). In fact, from time to time, some participants mentioned that they were able to react calmly to the important events they had experienced and that this was found interesting by themselves or by others. For example, Gizem said that there was a major earthquake on a trip abroad, but she did not panic and somehow could remain calm. Similarly, when Melis was misdiagnosed with malignant melanoma, she stated that she felt calm and coped well. Those support the idea that anxiety is associated with the imaginary structure of the ego because the subject is perpetually threatened by imaginary castration (Burgess, 2017).

The pleasure, that seems to be taken from feeling sick, was explained by Freud in detail. According to him, narcissistic investment was made in the bodily organs that eroticize the organs, and this investment holds pleasure and pain at the same time (Starcevic & Lipsitt, 2001, p. 187). Lacan’s explanation of enjoyment was important at that point. He used the term “jouissance”, which includes both pain and pleasure. Experiencing enjoyment as a pain indicated the paradoxical situation in which the subject gets unconscious satisfaction from his symptoms, which was also explained as a primary gain from illness by Freud (Evans, 1996). Anxiety increasing efforts that seem to be aimed at first reducing anxiety may be related to the unconscious pleasure of people from their symptoms. In this study, although no questions were asked directly on that kind of pleasure, due to it being an unconscious pleasure, various inferences were made by considering what the participants explained in the interviews. First of all, the source of pleasure was not being sick itself, but the things it relates to. On the other hand, participants said that they associate illnesses with being dependent to the care from others and not becoming self-sufficient while expressing their concerns about these, but on the other hand, they explained how they took care and support from the people around them

due to their somatic complaints and feelings of anxiety. Hence, they may not be able to get back from complaining and at the same time maintaining the symptoms involuntarily, since their symptoms simultaneously contain both the fear and the wish to be dependent, or at least protection from loneliness as an unconscious motive. Participants were more concerned about chronic illnesses such as cancer, which will require serious care, and at the same time they were constantly imagining that they have such illnesses. This can be regarded as a sign that such illnesses are both feared and unwittingly desired. Moreover, most of the participants talk about the fact that they have someone who takes them to the doctor because of their symptoms or they are in a situation where they are not alone or want to stay alone. When it is thought that one of the biggest fears is to be dependent on someone for reasons such as losing functionality and being unable to work, it can be said that both having a fear of being dependent and making themselves connected to others through anxiety or somatic symptoms occur simultenously. In the example of İrem, she explained that there was no mourning in her family for her sibling who died due to birth complications. She also said that she was afraid of cancer, but she read the blogs of cancer patients in the deadly phase and tries to imagine death. In a way, she practiced the death process and she might try to give a meaning to it. Thus, the enjoyment of feeling anxiety about becoming ill could be related to loss issues, including separation and death. In addition to practicing the issue of death, İrem's close relationship with his father or her husband throughout health concerns indicated that the complained symptom has some unconscious or conscious gains for the person.

While interacting with me in the position of a researcher and also as a mental health professional, expressions such as “rest assured that”, “do not suppose that I am exaggerating”, “really” emerged as important points. Those expressions were considered as an effort to call the attention of the other person (in that case me, but the other person could be any health care professional) to their difficulties. According to the Lacanian perspective, there is a call for the presence of the analyst (Nasio, 1998). Similarly, this communication style of the participants can be evaluated as a call to physical or mental health care professionals to get them involved. The frequent use of words such as “well, I mean, you know” by the participants seemed an attempt to explain themselves better and this might be a part of strengthening this call.

Based on clinical observations, Meltzer identified two distinctive complaint patterns. In the first one, the subject complains that their symptoms remain unnoticed, and in the second one, everybody notices the symptom. While the first pattern refers to changeable and mobile hypochondriacal symptoms, the second one refers to somatic delusions (Leader, 2004). In

“Studies on Hysteria”, Freud made a description of the hypochondriacal symptom defined by Meltzer as

> When a certain kind of subject “describes his pains, he gives an impression of being engaged in a difficult intellectual task to which his strength is quite unequal... He rejects any description of his pains proposed by the physician, even though it may turn out afterward to have been unquestionably apt. He is clearly of the opinion that language is too poor to find words for his sensations and that those sensations are something unique and previously unknown, of which it would be quite impossible to give an exhaustive description. For this reason, he never tires of constantly adding fresh details, and when he is obliged to break off, he is sure to be left with the conviction that he has not succeeded in making himself understood by the physician. (Freud 1895b, p136).

Those ideas of Freud may be the explanation behind why the call to the expert is endless. This hypochondriacal symptom aimed toward the articulation of a question instead of establishing certainty was also linked with a demand for love. Thus, there is expected to be an increase in hypochondriacal concerns in a love relation, but usually, quite the opposite is found: When the individual is no longer in a love relationship his or her complaints increase (Leader, 2004). Considering the association between the participants' romantic relationships and hypochondriac complaints, it can be said that hypochondriacal concerns exist for those both being in a love relation and not being in a love relation. Married participants generally said that their spouses were not interested enough in their somatic complaints. If somatic complaints are a demand for love, then it can be argued that the satisfaction of a person from that relationship plays a very effective role. In other words, whether a person is in a romantic relationship or not may not mean anything by itself. The continuity of the somatic complaints of the participants who do not have any complaints from their partners could be related to ensuring the continuity of the interest received from the somatic complaints as explained in the “benefits of being/feeling ill” section below as well.

4.3. Every Cloud Has a Silver Lining: Benefits of Being/Feeling Ill

Stuart and Noyes (1999) explained that since anxiously attached individuals did not get enough attention when they were sick as a child, they may be trying to get attention by using somatization in their adulthood. Most of the participants, however, explained how much their anxious parents fell on them when they became ill, in contrast with the argument of Stuart and Noyes. Also, this finding of the study differs from the findings of a qualitative study on hypochondria. Papis (2015) reported that participants of that study said their emotional needs were unmet by their parents, unlike the majority of the participants in the current study.

Overprotective parents were found in the family background of the individuals with hypochondriac complaints by a lot of research (e.g., Bianchi, 1971; Baker & Merskey, 1982). As exceptional cases, Fadime and Öykü clearly expressed that their parents were not interested in them enough. Although Fadime said that she has not received enough care in her nuclear family life and also in her marriage, she stated that her children and neighbors are caring for her because she's sick. Öykü, on the other hand, explained that even though her father was not interested in her as a child, he was interested after her accident. She also informed that her mother was interested with his brother due to him being sick. Therefore, it can be concluded that one of the important factors for the appearance and continuity of somatization is not that the individual cannot receive care and attention when she/he is ill, contrarily, bodily complaints bring attention and care. Supporting this idea, in the study of Levy (1932), using actual illness for receiving care and attention was one of the factors associated with the development of hypochondriacal symptoms. Receiving attention and care as a result of being or feeling ill was explained in the literature as secondary gain (Wahl, 1963; Craig, Drake, Mills, & Boardman, 1994; Sata & Munday, 2017).

Another benefit of health anxiety was that it was a way of coping with other life problems. This can be explained by the fact that familiar situations, namely somatic symptoms and anxiety about these symptoms, are more preferable than other situations that the individual does not know how to cope with. In other words, this shift can be explained by a kind of relaxing effect of familiarity: familiarity with problems about health. Demet is an example saying that whenever she was upset or had a problem that she had difficulty in coping with, her increasing health problems would help her to forget those. As stated in the article of Kirmayer and Young (1998), although some characteristics and prevalence vary from culture to culture, somatization is not unique to a single culture; on the contrary, it is the most common way of expressing emotional distress worldwide. Participants who say that somatic symptoms increase when they are not feeling well psychologically confirm this information. According to Mental Health Profile Report of Turkey (Erol, Kılıç, Ulusoy, Keçeci, & Şimşek, 1998), psychogenic pain, that is defined as physical pain associated with mental, emotional and behavioral factors, was the most frequent psychiatric diagnosis. This finding showed that the expression of distress through the body is common in Turkey as well, which was consistent with the results of the current study. Using the body as a way of communication in Eastern cultures was more common than in Western cultures. This pattern could be explained by the fact that in Eastern cultures somatization is less stigmatized compared to other psychiatric disorders which were believed to be purely "mental" such as depression (Raguram, Weiss, & Channabasavanna, 1996), and applying to health services due to physical symptoms was an

easier and perceived as more legitimate (Escobar et al., 1989 as cited in Şahin, Türkcan, Belene, Yeşlilbursa, & Yurt, 2009). One of the participants of the current study, Duru, exemplified this situation by stating that she felt guilty when she thought that the source of her problems was psychological; but this guilt disappeared when she thought the source was physiological. Furthermore, as Kirmayer and Young (1998) stated, the language of illness and healing depends on which medical tradition is used. In some interviews, participants preferred to use "rahatsızlık" to refer to their somatic complaints or their anxiety. In Turkish, the first meaning of the term is to be disturbed, restlessness, and the second meaning is "illness". Therefore, the word "rahatsızlık" in Turkish somehow embodies psychological distress. In Turkish, the relationship between physical problems and psychological problems is reflected in the meaning of words. For instance, one of the translations of sickness or disease was "dert" in Turkish, which is a word whose first meaning is distress. Freud's argument that physical symptoms are created by the ego to protect itself from threatening external situations and to feel relief could be an explanation for that (Sata & Munday, 2017). There were some culturally interesting points in the interviews. For example, Fadime seemed to emphasize that the somatic problems she is experiencing are not in her hands by saying that illnesses come from God. It has been shown in numerous studies that religious belief has a negative relation with various psychological disorders such as depression or substance abuse as shown in the review done by Koenig and Larson (2001). However, in this study, no evidence has been found that it has a positive effect on health anxiety for the participants who claimed that they are religious.

As a consequence of experiencing problems with health, participants' statements also showed how their priorities changed and health has surpassed everything. This is consistent with what Segall (1976) explained. According to him, once people thought that they were ill and adopt the sick role, they have right to be exempt from normal activities. Enhancement of self-care, self-acceptance, and self-worth were the consequences of putting health above all the things. This is also consistent with the idea that self-centeredness was a shared feature by individuals with hypochondriac symptoms (Fenichel, 2005). It was observed that the socio-economic level of the participants made a difference in what kind of responsibilities the illness provides relief. For Fadime and Melek, whose educational level and economic status are lower than other participants, being sick or feeling sick reduced their responsibilities in terms of not doing housework, whereas, for participants with higher socioeconomic status, the illness provided more comfort in terms of academic responsibilities. Moreover, relief from responsibilities felt for the things that failed because of an illness resulted in a decrease in guilt feelings, as in the case of Demet. According to the literature, attributing distress to somatic reasons instead of the emotional difficulties protect the individual from feeling a loss of control and the negative

effects of psychiatric diagnoses on self-esteem (Kirmayer & Young, 1998), which might be the explanation behind the decrease in guilt feelings. Thus, it has been suggested that efforts for the individuals to understand that the source of their problems is psychological should take the benefit-loss balance into consideration. One of the most important consequences of thinking that the problems arise from physiological reasons is that it reduces the likelihood of seeking and accepting psychiatric support (Kirmayer & Young, 1998). This can be explained by the fact that even though most of the participants in the study receive or are considering psychological support, they cannot prevent themselves from attending doctors in other branches.

4.4. Relations of the Four Themes with Each Other

Although producing a model about hypochondriasis was not the aim of the current study, the found four themes and their relations with each other revealed a preliminary model that must be explored either with other qualitative methodologies such as grounded theory, or other quantitative research methods. The associations among the four superordinate themes can be explained as follows. First of all, loss as an unfinished business was at the core of the (health) anxiety, and anxiety was thought to appear concerning the loss. Getting within the symptom more and also making a call to an expert were ways of both coping with the anxiety and at the same time “nurturing” the anxiety. As can be seen in the extracts, participants’ behavioral or cognitive preoccupation with health issues and even their health related-career choices did not help them to find out “what is wrong with them” and relax. Therefore, they thought that they need also a specialist who could find the answer and find solutions for themselves. Duru, for instance, stated that her family members could not act their way out of a paper bag since they were very anxious individuals while explaining why she needs a specialist. Thus, the presence of an anxious parent, as the majority of the participants stated, might have led the participants to consult an outside specialist. Applying to the specialists to get an answer could be related to a need for the symbolization of loss. However, their expectations from the specialists, who were mainly physicians, were either not met or even if they said that their expectations were met, their symptoms did not end completely and their relief was not long-term. When patients were not satisfied by the specialists, which is already impossible, they did an internet search or they chose professions that may have more information about illnesses although these may sometimes make them more anxious. Considering the continuity of the symptoms, it can be said that participants had some conscious or unconscious gains as shown in the last theme, “Every cloud has a silver lining: Benefits of being/feeling ill”; and these gains may be one of the explanations for the continuation of the symptoms. As a result, it is possible to summarize the findings obtained

from the interviews as such: health anxiety provides something that a person could organize around about the fact that loss cannot be handled, and then the actions are carried out both for the continuation and elimination of the anxiety. All the unconscious and conscious benefits are in the center covering those.

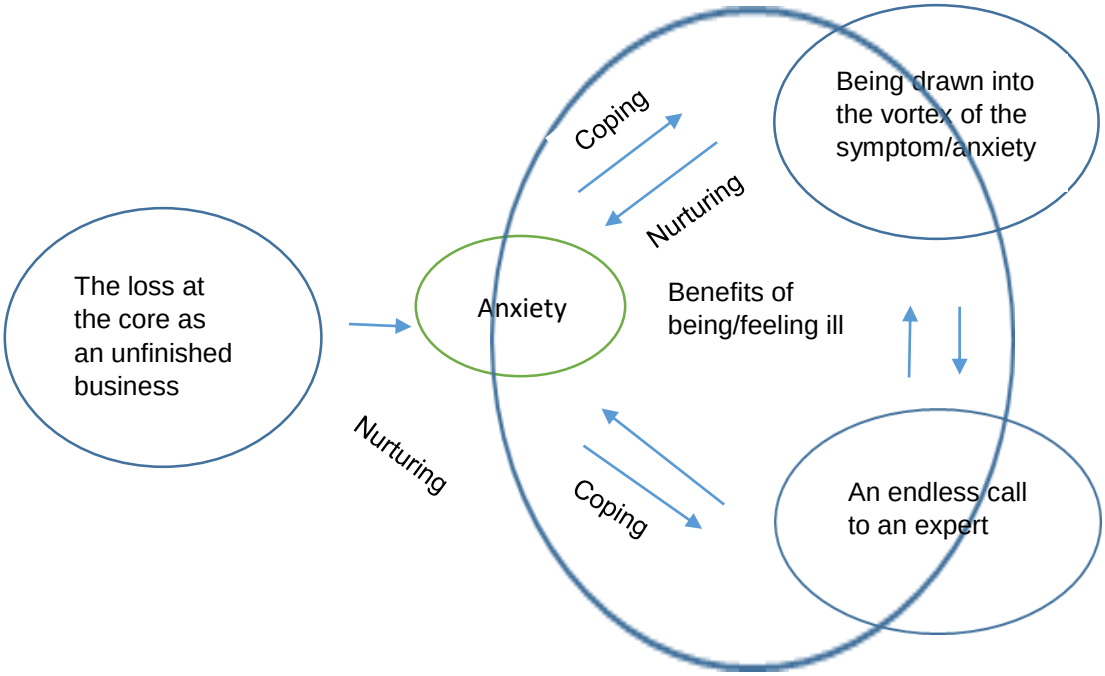

Figure 1. Preliminary model showing the relationship between the themes of the study

4.5. General Discussion

Classification of hypochondriac symptoms has been a controversial issue. In DSM-V, instead of hypochondriasis, two new categories were added. The rationale behind constituting two categories, somatic symptom disorder and illness anxiety disorder, was based on differentiating somatic symptoms from anxiety about the illness without physical symptoms (APA, 2013). This differentiation is based on a mind-body dualism of Western medicine trying to differentiate affective, anxiety, dissociative, and somatic symptoms from each other, but since being in the intersection of these anxiety and somatic symptoms, hypochondria cannot be separated into two as such (Kimayer & Young, 1998). It has been revealed in the interviews that such a separation is problematic; those two “distinctive” categories seemed to be intertwined. As can be seen from the demographic information table (Table 3) and the provided information about the participants in the results section, most of the participants had somatic

complaints, such as headaches, various pains, or wounds which were either diagnosed by physicians or sometimes not. Those somatic complaints were occasionally considered as a sign of more serious health problems by the participants, but still, most of the participants accepted that psychological state had an important role in their distress or even in their physical problems. Besides, the “sterile” approach adopted by DSM to classify diagnoses is problematic when it is considered that individuals with illness anxiety showed high comorbidity with some other categories, such as panic disorder and obsessions. Regarding this, there was a debate on whether hypochondria is a form of obsessive-compulsive disorder (OCD) or not. Abramowitz and Braddock (2006) discussed that the repetitive reassurance seeking in hypochondria functions similarly to the repetitive compulsive behaviors in OCD. Prevention of feared outcome, decreasing distress, and preservation of threat perception were those functions. Based on the overlapping features, they argued that hypochondriasis is a form of OCD. The intertwining of the concepts was manifested itself in the participants’ expressions that some participants named their conditions as “health obsession". Moreover, Sevil explained that her fear of death comes before her health anxiety and it was accompanied by her obsessive thoughts about being contaminated by germs. The central role of death anxiety in OCD was discussed in the literature, as well. Menzies, Menzies, and Iverach (2015) reported that contamination and death fear were linked with washing and checking behaviors explicitly by those who perform these behaviors. When comorbidity of hypochondria with panic attack and obsessions were evaluated together with the presence of fear of death in all three, it can be suggested that further evaluation of the role of fear of death in anxiety is required. In the DSM approach, a classification has been made based on the symptoms identified for each diagnostic category, but this leads to the generating categories in which the boundaries between them and their functions are not clear. Therefore, the argument that new diagnostic criteria are not a solution to the problems of DSM-IV (Brakoulias, 2014; Ghanizadeh & Firoozabadi, 2012) was supported by the current study.

One of the aims of the study is to understand how health anxious individuals perceive their bodies. Participants’ statements about the body appeared from time to time in the quotations given to clarify the themes, but no separate theme has been constructed due to not emerging as a strong enough theme. One of the reasons was that participants did not provide any information about how they perceive their own body or how they relate to their bodies unless specifically asked. In addition, “What does your body mean to you?” was the question that participants had the most difficulty in understanding and answering. However, since the body has been an important part of health anxiety, it might be better to make a discussion about it. Although the participants tried to describe their bodies as if they were describing a physical body, their expressions contained elements of having expectations of their bodies, that they

were disappointed, that they needed to protect it, and that they sometimes perceived it as something uncontrollable. For example, Duru explained that she did not like her body since it betrayed her by not being healthy. She also stated that she expected it to be stronger and if it were healthy, she would not be so busy with it and would feel complete. Thus, it is possible to say that each participant gave personal meaning to their bodies, which supports the idea that the body is not just a physical entity as Freud and Lacan argued (Burgoyne, 2004; Gessert, 2004).

There was no difference between the genders in terms of what illnesses mean for them. The association of illnesses with powerlessness or loss of dignity and functionality was expressed by both male and female participants. This may be because most of the interviewed women had higher education levels and had a career. More importantly, femininity or masculinity is about how a person positions himself/herself rather than pointing to a biological position (Stets & Burke, 2000) and gender identity may have a more effective role than gender.

4.6. Strengths and Limitations of the Study, and Clinical Implications of the Findings

The participants had no difficulty in talking about their illnesses or their anxiety of becoming ill. Even when they were asked to introduce themselves, they often started to directly talk about those issues. This situation has been evaluated as an indicator of the fact that people with health anxiety establish a relationship with others by talking about their illnesses and their transfers develop rapidly in that sense. This supports the idea that the imagined, feared, or exaggerated illnesses could provide a set of signifiers around which the individual is organized and can contact with others (Butler-Rees, 2011). Since the participants were comfortable with talking about the topic of the research, this partially eliminated the disadvantages of having only one interview with them. Nevertheless, it may be seen as a limitation of the study that at least a second interview was not conducted to see what the impact of the first interview had on the participants, to elaborate some issues, if necessary, and to observe what participants would like to talk about more after the first interview, which was mainly focused on illnesses.

Another limitation of the study could be the limited number of male participants as compared to the number of female participants. Nevertheless, the ratio of male participants to female participants represented the prevalence rates in the community. According to the findings of Mental Health Profile Report of Turkey, the rate of patients diagnosed with hypochondriasis was 0.8% for women and 0.3% for men (Erol, Kılıç, Ulusoy, Keçeci, & Şimşek, 1998).

Both medical doctors and mental health professionals encounter people with hypochondriac complaints. It would not be right to think that medical doctors are only related to the physical symptoms of those people. It is seen that the physical-psychological distinction made by the experts do not correspond with the reality of people with hypochondriac complaints. Even if there is no physiological basis for the illness which they thought they had, these individuals experienced it as if it has that basis. Therefore, it would not help the patients to tell that he/she does not have a physiological problem or he/she is physiologically well. Moreover, in the interviews, participants referred to the importance of the doctor's knowledge when explaining what they expect from physicians. However, participants emphasized not only the knowledge of the physicians, but also how much he/she understood himself/herself, whether he/she was empathetic, or whether he/she put him/her off. Rather than the information itself, the relationship between the physician and the patient becomes more important, showing the importance of transference. Also, it was observed that the participants did not comply with the treatment plan given by the doctors whom they did not trust and did not establish a good relationship with them, and even they adhere to the treatment given by such a physician, they talked about the side effects. The importance of the alliance between patients and the professionals working with them is supported by many studies in the literature (e.g., Weck, Richtberg, Jakob, Neng, & Höfling, 2015; Xiong, Bourgeois, Chang, Liu, & Hilty, 2007). Therefore, the findings of the study would be important not only for mental health workers but also for every professional working with people having health anxiety.

Furthermore, while working with people having hypochondriacal complaints, it s important to pay attention to the issues related to loss reported by the participants in relation to the emergence of health concerns. Since the loss seems not been symbolized, it is thought that talking about it would reduce the somatization. Indivduals with the psychotic structure having hypochondriac complaints were not interviewed due to the scope of the study. Therefore, such a recommendation can only be made for people whose hypochondriac symptoms do not have delusional characteristics.

Finally, this study showed that attempting to point out the relationship of physical complaints with psychological factors could be an unnecessary intervention that will not have any effect when we think that most of the participants have already expressed it themselves. Similarly, the participants mostly accepted the excessiveness of their health anxiety as it was also found by Beckett (2009). Therefore, people with hypochondriac complaints may not have a poor insight contrary to popular belief. It should be noted, however, that one explanation for this may be that the participants were chosen from people who already accepted their health concerns as high. Moreover, given that the relieving effect of the information provided to the

participants regarding their health status is short-term and that they are cyclically pursuing the knowledge of "What is wrong with me", it is important that the focus of the therapy is not to try to provide an explanation that physical symptoms do not indicate a serious condition because these quests are perpetual, and in fact they are not the search for what they seek, but the search itself. In other words, it would be a wasted effort to give those individuals a biological explanation of their physical symptoms. As a result, therapists working with patients with hypochondria should help the patient understand the continuity of their desire to know if something is in themselves and what it is, after establishing a therapeutic alliance with the patient. The importance of interpersonal interaction was proposed by Schilder. He puts it into the origin of the subjective experience of one's body (Schilder, 2013). The reason why hypochondria is challenging for both medical doctors and mental health professionals, or even an ignored issue for a while (Wahl, 1963) is perhaps because they are disappointed with these patients who are not satisfied with the information they provide.

REFERENCES

Abramowitz, J. S., & Braddock, A. E. (2006). Hypochondriasis: conceptualization, treatment, and relationship to obsessive-compulsive disorder. *Psychiatric Clinics*, *29*(2), 503–519. doi:10.1016/j.psc.2006.02.008

Abramowitz, J. S., Deacon, B. J., & Valentiner, D. P. (2007). The Short Health Anxiety Inventory: Psychometric properties and construct validity in a non-clinical sample. *Cognitive Therapy and Research*, *31*(6), 871–883. doi:10.1007/s10608-006-9058-1

Alberts, N. M., Hadjistavropoulos, H. D., Jones, S. L., & Sharpe, D. (2013). The Short Health Anxiety Inventory: A systematic review and meta-analysis. *Journal of Anxiety Disorders*, *27*(1), 68–78. doi:10.1016/j.janxdis.2012.10.009

American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Arndt, J., Routledge, C., Cox, C. R., & Goldenberg, J. L. (2005). The worm at the core: A terror management perspective on the roots of psychological dysfunction. *Applied and Preventive Psychology*, *11*(3), 191–213. doi:10.1016/j.appsy.2005.07.002

Aydemir, O., Kırpınar, I., Satı, T., Uykur, B., & Cengisiz, C. (2013). Reliability and validity of the Turkish version of the Health Anxiety Inventory/Sağlık Anksiyetesi Ölçeği'nin Türkçe için güvenilirlik ve geçerlilik çalışması. *Archives of Neuropsychiatry, 50*(4), 325–332. doi:10.4274/npa.y6383

Baker, B., & Merskey, H. (1982). Parental representations of hypochondriacal patients from a psychiatric hospital. *The British Journal of Psychiatry*, *141*(3), 233–238. doi: 10.1192/bjp.141.3.233

Barsky, A. J., Frank, C. B., Cleary, P. D., Wyshak, G., & Klerman, G. L. (1991). The relation between hypochondriasis and age. *The American Journal of Psychiatry*, *148*(7), 923–928.

Barsky, A. J., & Klerman, G. L. (1983). Overview: Hypochondriasis, bodily complaints, and somatic styles. *The American Journal of Psychiatry*, *140*(3), 273–283.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, *61*(2), 226–244.

Baumgartner, S. E., & Hartmann, T. (2011). The role of health anxiety in online health information search. *Cyberpsychology, Behavior, and Social Networking*, *14*(10), 613–618. doi:10.1089/cyber.2010.0425

Baur, S. (1989). *Hypochondria: Woeful imaginings*. Berkeley: University of California Press.

Beckett, J. J. (2009). *Health anxiety and hypochondriasis: The patient's perspective* (Master's thesis, Massey University, Albany, New Zealand). Retrieved from https://mro.massey.ac.nz/handle/10179/12724

Berrios, G. E. (2001). Hypochondraisis: History of the concept. In V. Starcevic & D. R. Lipsitt (Eds.), *Hypochondriasis: Modern perspectives on an ancient malady* (pp. 3–20). Oxford University Press.

Bianchi, G. N. (1971). Origins of disease phobia. *Australian and New Zealand Journal of Psychiatry*, *5*(4), 241–257. doi:10.1080/00048677109159654

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, *5*(3), 214–224. doi:10.1080/14780880802314304

Bowlby, J. (1969). *Attachment and loss: Vol. 1: Attachment.* London: Hogarth Press.

Bowlby, J. (1973). *Attachment and loss. Vol. 2: Separation: Anxiety and anger.* New York: Basic Books.

Brakoulias, V. (2014). DSM-5 bids farewell to hypochondriasis and welcomes somatic symptom disorder and illness anxiety disorder. *Australian and New Zealand Journal of Psychiatry*, *48*(7), 688–688. doi:10.1177/0004867414525844

Brown, F. (1936). The bodily complaint: A study of hypochondriasis. *Journal of Mental Science*, *82*(339), 295–359.

Bunge, M. (2014). Introduction.*The mind-body problem: A psychobiological approach (pp.* xiii–xvi). Elsevier.

Burgess, J. P. (2017). For want of not: Lacan's conception of anxiety. In E. Eklundh, A. Zevnik, & E-P. Guittet (Eds.), *Politics of anxiety* (pp. 17–36). London: Rowman & Littlefield Ltd.

Burgoyne, V. (2004). Editorial - Spring 04. *The Journal of the Centre for Freudian Analysis and Research*,*14*, 4–8.

Butler-Rees, E. (2011). *Body dysmorphic disorder: A psychoanalytic perspective*. Higher Diploma Final Year Project, Dublin Business School.

Canellopoulos, L. (2010). The bodily event, jouissance and the (post) modern subject. *Recherches en Psychanalyse*, *10*(2), 321a–328a. doi:10.3917/rep.010.0141

Chan, Z. C., Fung, Y. L., & Chien, W. T. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process. *The Qualitative Report*, *18*(30), 1–9.

Chapman L. (1999). Psychosomatic disorders: A psychoanalytic category. Retrieved from http://www.therapeia.org.uk/documents/Psychosomatics.pdf

Chemouni, L. (2001). De l'hypocondrie aux pathonévroses. L'apport de Ferenczi. *L'évolution Psychiatrique*, *66*(1), 25–42. doi:10.1016/S0014-3855(01)90003-9

Christogiorgos, S., Tzikas, D., Widdershoven-Zervaki, M. A., Dimitropoulou, P., Athanassiadou, E., & Giannakopoulos, G. (2013). Hypochondriacal anxieties in adolescence. *Open Psychology Journal*, *6*, 6–9.

Comay, R. (n.d.) Hypochondria and its discontents, or, the geriatric sublime. *Crisis & Critique, 3*(2), 41–58. Retrieved from http://crisiscritique.org/special09/comay.pdf

Connelly, L. M. (2016). Trustworthiness in qualitative research. *Medsurg Nursing*, *25*(6), 435–437.

Conroy, R. (2015). Sample size: A rough guide. *Beaumontethics [referenced 30. September 2015].* Retrieved from http://www. beaumontethics. ie/docs/application/samplesizecalculation.pdf.

Cortina, J. M. (1993). What is coefficient alpha? An examination of theory and applications. *Journal of Applied Psychology*, *78*(1), 98–104.

Cronin, C., & Lowes, J. (2016). Brief encounters with qualitative methods in health research: Phenomenology and interpretative phenomenological analysis. *The Cumbria Partnership Journal of Research, Practice and Learning, 5*(1), 8–12.

Craig, T. K. J., Drake, H., Mills, K., & Boardman, A. P. (1994). The South London Somatisation Study II: Influence of stressful life events, and secondary gain. *The British Journal of Psychiatry*, *165*(2), 248–258.

Declercq, F. (2004). Lacan's concept of the real of jouissance: Clinical illustrations and implications. *Psychoanalysis, Culture & Society*, *9*(2), 237–251. doi:10.1057/palgrave.pcs.2100019

Doherty-Torstrick, E. R., Walton, K. E., & Fallon, B. A. (2016). Cyberchondria: Parsing health anxiety from online behavior. *Psychosomatics*, *57*(4), 390–400. doi:10.1016/j.psym.2016.02.002

Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, *44*(1), 131–142. doi:10.1016/j.ijnurstu.2005.11.026

Erol, N., Kılıç, C., Ulusoy, M., Keçeci, M., & Simşek, Z. (1998). *Türkiye ruh sağlığı profili raporu [Mental health profile report of Turkey]*. Ankara, Türkiye Cumhuriyeti Sağlık Bakanlığı Temel Sağlık Hizmetler Genel Müdürlüğü.

Evans, D. (1996). *An introductory dictionary of Lacanian psychoanalysis.* New York, Routledge.

Evans, D. (2017). From Kantian ethics to mystical experience: An exploration of jouissance. In D. Nobus (Ed.), *Key concepts of Lacanian psychoanalysis* (pp. 1–28). Karnac Books.

Feher-Gurewich, J. (2003). A Lacanian approach to the logic of perversion. In J. M. Rabate (Ed.), *The Cambridge companion to Lacan* (pp. 191–207). New York, Cambridge University Press.

Fenichel, O. (2005). *The psychoanalytic theory of neurosis*. Retrieved from Taylor & Francis e-Library.

Ferenczi, S. (1994). *First contributions to psycho-analysis* (E. Jones, Trans.). Karnac Books.

Florian, V., & Mikulincer, M. (1998). Symbolic immortality and the management of the terror of death: The moderating role of attachment style. *Journal of Personality and Social Psychology*, *74*(3), 725–734.

Freud, S. (1895a). On the grounds for detaching a particular syndrome from neurasthenia under the description “Anxiety Neurosis”. In J. Strachey (Ed.) & A. A. Brill (Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 85–115). London: Hogarth Press.

Freud, S. (1895b). Fräulein Elisabeth von R, case histories from studies on hysteria. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud, Volume II (1893-1895):* Studies on hysteria (pp. 135–182). London: The Hogarth Press and the Institute of Psycho-analysis.

Freud, S. (1898). Sexuality in the Aetiology of the Neuroses. In J. Strachey (Ed.) & J. Bernays (Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 259–285). London: Hogarth Press.

Freud, S. (1917). A metapsychological supplement to the theory of dreams. In J. Strachey Ed.) & C. M. Baines (Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 222–236) (Original work published 1917). London: Hogarth Press.

Freud, S. (1926). Inhibitions, symptoms and anxiety. In J. Strachey, & A. Freud (Eds.), *The standard edition of the complete psychological works of Sigmund Freud, Volume XX (1925-1926): An autobiographical study, inhibitions, symptoms and anxiety, the question of lay analysis and other works* (pp. 75–176). London: The Hogarth Press.

Freud, S. (1958). Contributions to a discussion on masturbation. In J. Strachey (Ed.), *The Standard edition of the complete psychological works of Sigmund Freud, Volume XII (1911-1913): The case of Schreber, papers on technique and other works* (pp. 239–254). (Original work published 1912). London: The Hogarth Press and the Institute of Psycho-analysis.

Freud, S. (2014). *On narcissism: An introduction*. Read Books Ltd. (Original work published 1914). Read Books Ltd.

Furer, P., & Walker, J. R. (2008). Death anxiety: A cognitive-behavioral approach. *Journal of Cognitive Psychotherapy*, *22*(2), 167–182. doi:10.1891/0889-8391.22.2.167

Gessert, A. (2004). The Body in Hypochondria - Some Thoughts. *The Journal of the Centre for Freudian Analysis and Research, Spring*(14), 11–17.

Ghanizadeh, A., & Firoozabadi, A. (2012). A review of somatoform disorders in DSM-IV and somatic symptom disorders in proposed DSM-V. *Psychiatria Danubina*, *24*(4), 353–358.

Grinnell, G. (2010). *The age of hypochondria: Interpreting romantic health and illness*. Basingstoke: Palgrave Macmillan.

Gutwinski-Jeggle, J. (1997). Hypochondria versus the relation to the object. *International Journal of Psycho-analysis*, *78*, 53–68.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *52*(3), 511–524.

Hollifield, M. (2001). Hypochondriasis and personality disturbance. In V. Starcevic & D. R. Lipsitt, (Eds.), *Hypochondriasis: Modern perspectives on an ancient malady* (pp. 103–126). Oxford University Press.

Holloway, I. (2005). *Qualitative research in health care*. McGraw-Hill Education (UK).

Hunter, J. J., & Maunder, R. G. (2001). Using attachment theory to understand illness behavior. *General Hospital Psychiatry*, *23*(4), 177–182. doi:10.1016/S0163-8343(01)00141-4

Jana, A. K., Praharaj, S. K., & Mazumdar, J. (2012). Current debates over nosology of somatoform disorders. *Industrial Psychiatry Journal*, *21*(1), 4–10. doi:10.4103/0972-6748.110939

Katzenelbogen, S. (1942). Hypochondriacal complaints with special reference to personality and environment. *American Journal of Psychiatry*, *98*(6), 815–822. doi:10.1176/ajp.98.6.815

Kendell, R. (2001). The distinction between menta and physical illness. *British Journal of Psychiatry, 178*(6)*,* 490–493. doi:10.1192/bjp.178.6.490

Kirmayer, L. J., & Young, A. (1998). Culture and somatization: Clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*, *60*(4), 420–430.

Kirpinar, I., Deveci, E., Kilic, A., & Zihni Camur, D. (2016). Somatization disorder and hypochondriasis: as like as two peas?. *Anatolian Journal of Psychiatry/Anadolu Psikiyatri Dergisi*, *17*(3), 165–173. doi:10.5455/apd.201002

Klein, M. (1935). A contribution to the psychogenesis of manic-depressive states. *International Journal of Psycho-Analysis*, *16*, 145–174.

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing, 21(5), 827–836.* doi:10.1046/j.1365-2648.1995.21050827.x

Kocjan, J. (2016). Short Health Anxiety Inventory (SHAI)-Polish version: Evaluation of psychometric properties and factor structure. *Archives of Psychiatry and Psychotherapy*, *18*(3), 68–78. doi:10.12740/APP/64276

Koenig, H. G., & Larson, D. B. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry*, *13*(2), 67–78.

Kreitler, S. (2018). The mind-body problem: The perspective of psychology. *Open Journal of Philosophy, 8,* 60–75. doi:10.4236/ojpp.2018.81006

Lacan, J. (1977). *The* Subversion of the subject and the dialectic of desire in the Freudian unconscious*.* In J. Lacan (ed.), *Ecrits: A selection* (pp. 292–325). New York: W. W. Norton and Company.

Leader, D. (2004). Hypochondria. *The Journal of the Centre for Freudian Analysis and Research,* (14), 18–26.

Levy, D. M. (1932). Body interest in children and hypochondriasis. *The American Journal of Psychiatry, 12,* 295–315. doi:10.1176/ajp.89.2.295

Lipowski, Z. J. (1988). Somatization: The concept and its clinical application. *American Journal of Psychiatry*, *145*(11), 1358–1368.

Lipsitt, D. R. (1974). Psychodynamic considerations of hypochondriasis. *Psychotherapy and psychosomatics*, *23*(1-6), 132–141.

Lipsitt, D. R. (2001). Psychodynamic perspectives on hypochondriasis. In V. Starcevic & D. R. Lipsitt (Eds.), *Hypochondriasis: Modern perspectives on an ancient malady* (pp. 183–201). Oxford University Press.

Lipsitt, D. R. (2014). Psychodynamic models and therapeutic approaches to hypochondriasis. In V. Starcevic & R. Noyes (Eds.), *Hypochondriasis and health anxiety: A guide for clinicians* (pp. 222–240). Oxford University Press.

Lipsitt, D. R. (2015). Hypochondriasis and somatization disorder: New perspectives. In H. Leigh & J. Streltzer (Eds.), *Handbook of consultation-liason psychiatry* (2nd ed., pp. 317–334). New York: Springer.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. In *Forum: Qualitative Social Research, 11*(3), Article 8. Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/1428

Maunder, R. G., & Hunter, J. J. (2001). Attachment and psychosomatic medicine: Developmental contributions to stress and disease. *Psychosomatic Medicine*, *63*(4), 556–567.

Menzies, R. G., Menzies, R. E., & Iverach, L. (2015). The role of death fears in obsessive-compulsive disorder. *Australian Clinical Psychologist, 1,* 6–11.

Mikail, S. F., Henderson, P. R., & Tasca, G. A. (1994). An interpersonally based model of chronic pain: An application of attachment theory. *Clinical and Psychology Review*, *14*, 1–16.

Nasio, J. D. (1998). *Five lessons on the psychoanalytic theory of Jacques Lacan*. SUNY Press.

Noyes, R. (2005). Hypochondriasis: A review. In M. Maj, H. S. Akiskal, J. Mezzich & A. Okasha (Eds.), *Somatoform disorders* (pp. 128–160). John Wiley & Sons.

Noyes, R., Stuart, S., Watson, D. B., & Langbehn, D. R. (2006). Distinguishing between hypochondriasis and somatization disorder: A review of the existing literature. *Psychotherapy and Psychosomatics*, *75*(5), 270–281. doi:10.1159/000093948

Okita, M., Kobori, O., Okita, K., Hasegawa, T., Shiraishi, T., & Iyo, M. (2016). The motivations and characteristics of seeking reassurance in health anxiety: A qualitative study of Japanese samples. *Chiba Medical Journal*, *92*(1), 1–9.

Pagalilauan, G. L. (2014). Psychiatric Diagnosis and Management in Primary Care. *Medical Clinics*, *98*(5), xvii–xix. doi:10.1016/j.mcna.2014.07.001

Papis, K. G. (2015). *Emotional intelligence and sociotropy-autonomy in young women with DSM-IV-TR hypochondriasis: A mixed-method study* (Doctoral dissertation, University of Wolverhampton, United Kingdom). Retrieved from https://wlv.openrepository.com

Parahoo, K. (2006). *Nursing research: Principles, process and issues*. Palgrave Macmillan, Basingstoke.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7–14. doi:10.14691/CPPJ.20.1.7

Pope, C., & Mays, N. (1995). Qualitative research: Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research. *British Medical Journal*, *311*(6996), 42–45.

Raguram, R. D. P. M., Weiss, M. G., Channabasavanna, S. M., & Devins, G. M. (1996). Stigma, depression, and somatization in South India. *American Journal of Psychiatry*, *153*(8), 1043–1049.

Redmond, J. (2014). *Ordinary psychosis and the body: A contemporary Lacanian approach*. Springer.

Richards, A. D. (1981). Self theory, conflict theory, and the problem of hypochondriasis. *The Psychoanalytic Study of the Child*, *36*(1), 319–337.

Risse, G. B. (2005). Mind–body enigma: Hysteria and hypochondriasis at the Edinburgh Infirmary. In *New medical challenges during the Scottish enlightenment* (pp. 311–349). Brill Rodopi.

Romanowicz, M., & Moncayo, R. (2014). How could Lacanian theory contribute to DSM V? Discussion of diagnosis of bipolar disorder and the controversy around grief versus clinical depression. *European Journal of Psychoanalysis*. Retrieved from https://www.journal-psychoanalysis.eu/how-could-lacanian-theory-contribute-to-dsm-5-discussion-of-diagnosis-of-bipolar-disorder-and-the-controversy-around-grief-versus-clinical-depression-3/

Rosenfeld, D. (1984). Hypochondrias, somatic delusion and body scheme in psychoanalytic practice. *International Journal of Psycho-Analysis*, *65*, 377–387.

Rosenfeld, H. A. (1958). Some observations on the psychopathology of hypochondriacal states. *International Journal of Psycho-Analysis*, *39*, 121–124.

Rosenfeld, H. A. (2018). *Psychotic states: A psychoanalytic approach*. Routledge.

Röder, C. H., Overbeck, G., & Müller, T. (1995). Psychoanalytische Theorien zur Hypochondrie, *Psyche*, *49*(11), 1068–1098.

Russo, J., Vitaliano, P. P., Brewer, D. D., Katon, W., & Becker, J. (1995). Psychiatric disorders in spouse caregivers of care recipients with Alzheimer's disease and matched controls: A diathesis-stress model of psychopathology. *Journal of Abnormal Psychology*, *104*(1), 197–204.

Salkovskis, P. M., Rimes, K. A., Warwick, H. M. C., & Clark, D. M. (2002). The Health Anxiety Inventory: Development and validation of scales for the measurement of health anxiety and hypochondriasis. *Psychological Medicine*, *32*(05), 843–853. doi:10.1017/S0033291702005822

Salkovskis, P. M., & Warwick, H. M. (1986). Morbid preoccupations, health anxiety and reassurance: A cognitive-behavioural approach to hypochondriasis. *Behaviour Research and Therapy*, *24*(5), 597–602. doi:10.1016/0005-7967(86)90041-0

Sata, M. J., & Munday, C. C. (2017). Primary and secondary gain. In V. Zeigler-Hill & T. K. Shackelford (Eds.), *Encyclopedia of personality and individual differences* (pp. 1–4). Springer International Publishing.

Scarella, T. M., Laferton, J. A., Ahern, D. K., Fallon, B. A., & Barsky, A. (2016). The relationship of hypochondriasis to anxiety, depressive, and somatoform disorders. *Psychosomatics*, *57*(2), 200–207. doi:10.1016/j.psym.2015.10.006

Schmidt, S., Strauss, B., & Braehler, E. (2002). Subjective physical complaints and hypochondriacal features from an attachment theoretical perspective. *Psychology and Psychotherapy: Theory, Research and Practice*, *75*(3), 313–332. doi:10.1348/147608302320365217

Schilder, P. (2013). *The image and appearance of the human body*. Routledge.

Segall, A. (1976). The sick role concept: Understanding illness behavior. *Journal of Health and Social Behavior*, *17*(2), 162–169.

Singh, K., Fox, J. R., & Brown, R. J. (2016). Health anxiety and internet use: A thematic analysis. *Cyberpsychology: Journal of Psychosocial Research on Cyberspace, 10*(2), 98–120. doi:10.5817/CP2016-2-4

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9–27. doi:10.1080/17437199.2010.510659

Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. In E. Lyons A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 35–50). Los Angeles, London, New Delhi, Singapore: Sage Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE.

Smith, J. A., Harre, R., & Van Langenhove, L. (1995). Idiography. In J. A. Smith, R. Harre & L. Van Langenhove (Eds), *Rethinking psychology*. London: Sage.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (pp. 51–80). London: Sage.

Starcevic, V., & Lipsitt, D. R. (2001). Introduction. *Hypochondriasis: Modern perspectives on an ancient malady* (pp. xi–xiv). Oxford University Press.

Starcevic, V., & Noyes, N. (2014). Introduction and key issues. *Hypochondriasis and health anxiety: A guide for clinicians* (pp. 1–7*).* Oxford: Oxford University Press.

Stathopoulos, G. (2017). Hypochondria: a review of its place in psychoanalytic theory. *The Psychoanalytic Quarterly*, *86*(2), 359–381. doi:10.1002/psaq.12143

Stegge, B. M., Tak, L. M., Rosmalen, J. G., & Voshaar, R. C. O. (2018). Death anxiety and its association with hypochondriasis and medically unexplained symptoms: A systematic review. *Journal of Psychosomatic Research*, *115*, 58–65. doi:10.1016/j.jpsychores.2018.10.002

Stets, J. E., & Burke, P. J. (2000). Femininity/masculinity. In E. F. Borgatta & R. J. V. Montgomery (Eds.), *Encyclopedia of sociology* (pp. 997–1005). New York: Macmillan.

Strachan, E., Schimel, J., Arndt, J., Williams, T., Solomon, S., Pyszczynski, T., & Greenberg, J. (2007). Terror mismanagement: Evidence that mortality salience exacerbates phobic and compulsive behaviors. *Personality and Social Psychology Bulletin*, *33*(8), 1137–1151. doi:10.1177/0146167207303018

Strubbe, G., & Vanheule, S. (2014). The subject in an uproar: A Lacanian perspective on panic disorder. *Journal of the American Psychoanalytic Association*, *62*(2), 237–266. doi:10.1177/0003065114527616

Stuart, S., & Noyes, R. (1999). Attachment and interpersonal communication in somatization. *Psychosomatics*, *40*, 34–43.

Sulkowski, M. L., Mariaskin, A., & Storch, E. A. (2011). Obsessive-compulsive spectrum disorder symptoms in college students. *Journal of American College Health*, *59*(5), 342–348. doi:10.1080/07448481.2010.511365

Swales, S. (2012). Perversion: A Lacanian psychoanalytic approach to the subject. New York, Routledge.

Şahin, E., Türkcan, A. S., Belene, A., Yeşilbursa, D., & Yurt, E. (2009). Somatizasyonda kültürel ve sosyolojik faktörler. *New/Yeni Symposium Journal, 47*(4), 187–193.

Taylor, R. B. (2016). *White coat tales: Medicine's heroes, heritage, and misadventures*. New York, NY: Springer-Verlag.

Thomä, H., & Kächele, H. (2012). *Psychoanalytic practice 2: Clinical studies*. Springer Science & Business Media.

Verhaeghe, P. (2001). Subject and body. Lacan's struggle with the real. In P. Verhaeghe (Ed.), *Beyond gender. From subject to drive* (pp. 65–97). New York: Other Press.

Verhaeghe, P. (2018). *On being normal and other disorders: A manual for clinical psychodiagnostics*. Routledge.

Wahl, C. W. (1963). Unconscious factors in the psychodynamics of the hypochondrical patient. *Psychosomatics*, *4*, 9–14.

Warwick, H. M. (1989). A cognitive-behavioural approach to hypochondriasis and health anxiety. *Journal of Psychosomatic Research*, *33*(6), 705–711.

Wearden, A., Perryman, K., & Ward, V. (2006). Adult attachment, reassurance seeking and hypochondriacal concerns in college students. *Journal of Health Psychology*, *11*(6), 877–886. doi:10.1177/1359105306069086

Weck, F., Richtberg, S., Jakob, M., Neng, J. M., & Höfling, V. (2015). Therapist competence and therapeutic alliance are important in the treatment of health anxiety (hypochondriasis). *Psychiatry Research*, *228*(1), 53–58. doi:10.1016/j.psychres.2015.03.042

Willig, C. (2001). *Introducing qualitative research in psychology. Adventures in theory and method*. Buckingham, Philadelphia: Open University Press.

Wilton, R. D. (2003). Locating physical disability in Freudian and Lacanian psychoanalysis: Problems and prospects. *Social and Cultural Geography*, *4*(3), 369–389. doi: 10.1080/14649360309069

Wintrebert, D. (2009). Hypochondria between belief and certainty. *L'Information Psychiatrique*, *85*(1), 43–49. doi:10.1684/ipe.2009.0427

Xiong, G. L., Bourgeois, J. A., Chang, C. H., Liu, D., & Hilty, D. M. (2007). Hypochondriasis: Common presentations and treatment strategies in primary care and specialty settings. *Clinical Practice*, *4*(3), 323–338. doi:10.2217/14750708.4.3.323

Yurdugül, H. (2008). Minimum sample size for Cronbach's coefficient alpha: A Monte-Carlo study. *Hacettepe Üniversitesi Eğitim Fakültesi Dergisi*, *35*(35), 1–9.

Zangrilli, Q. (2001, January 27). Hypochondria: A somatic paranoia. Retrieved from: http://www.psicoanalisi.it/psicosomatica/1486#.WSr_-Wjyjb1

APPENDICES

APPENDIX A: APPROVAL OF METU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

DUMLUPINAR BULVARI 06800
ÇANKAYA ANKARA/TURKEY
T: +90 312 210 22 91
F: +90 312 210 79 59
www.ueam.metu.edu.tr

Sayı: 28620816 469

06 Eylül 2017

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof.Dr. Özlem BOZO ;

Danışmanlığını yaptığınız doktora öğrencisi Burcu Pınar BULUT'un ***"Sağlık Kaygısı Yüksek Bireyler Vücutlarıyla ve Başkalarıyla Nasıl İlişki Kurarlar Yorumlayıcı Fenomenolojik Analizle Bir İnceleme"*** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek gerekli onay **2017-SOS-0146** protokol numarası ile **07.09.2017 – 30.12.2018** tarihleri arasında geçerli olmak üzere verilmiştir.

Bilgilerinize saygılarımla sunarım.

Prof. Dr. Ş. Halil TURAN
Başkan V

Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR
Üye

Doç. Dr. Yaşar KONDAKÇI
Üye

Doç. Dr. Zana ÇITAK
Üye

Yrd. Doç. Dr. Pınar KAYGAN
Üye

Yrd. Doç. Dr. Emre SELÇUK
Üye

APPENDIX B: INFORMED CONSENT FORM

Gönüllü Katılım Formu

Sayın Katılımcı;

Bu çalışma Prof. Dr. Özlem Bozo danışmanlığında, ODTÜ Psikoloji Bölümü Klinik Psikoloji Doktora öğrencisi Burcu Pınar Bulut tarafından sağlık kaygısı olan kişilerin deneyimlerini öğrenmek ve bu deneyimleri nasıl anlamlandırdıklarını anlamak amacıyla yürütülmektedir.

Çalışma kapsamında uygulanacak olan anketlerin amacı çalışmanın ikinci aşamasının katılımcılarını belirlemektir. İlk aşamada uygulanacak anketlerin sonucuna göre açık uçlu soruların sorulacağı görüşmelerin yapılıp yapılmayacağına karar verilecektir. Bu görüşmeler ise ses kayıt cihazı ile kayıt altına alınacaktır. Görüşmelerde vereceğiniz isim ve kimliğinizi ortaya çıkarabilecek bilgiler dâhil tüm bilgiler yalnızca araştırmacılar tarafından değerlendirilecektir. Bu çalışmadan elde edilecek bilgiler gizlilik esasına uygun bir biçimde, kişilerin kimlik bilgilerinin kesin gizliliği esas alınarak, sunum ve bilimsel yayınlarda kullanılabilecektir. Çalışmaya katılım tamamıyla gönüllülük esasına dayanmaktadır ve katılım sırasında herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, cevaplama işini istediğiniz anda bırakmakta serbestsiniz. Katılımınız için şimdiden teşekkür ederiz.

Çalışma hakkında daha fazla bilgi almak için ODTÜ Psikoloji Bölümü öğrencisi Burcu Pınar Bulut (E-posta:burcupinarbulut@gmail.com) ile iletişim kurabilirsiniz.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum. (Formu doldurup imzaladıktan sonra uygulayıcıya geri veriniz).

Ad Soyad	Tarih	İmza
_____	----/----/-----	_____

*If filled in online, only the e-mail address was requested instead of the information above.

APPENDIX C: DEMOGRAPHIC INFORMATION FORM

Demografik Bilgiler:

Yaşınız:

Medeni haliniz:

1. Bekar _____ 2. Evli _____ 5. Diğer (belirtniz).....

3. Boşanmış _____ 4. Dul _____

Eğitim Durumunuz:

1. İlkokul _____ 2. Ortaokul _____ 3.Lise _____

4. Ön Lisans _____ 5.Lisans _____ 6. Lisansüstü _____

7. Diğer _____

Çalışıyor musunuz?: _____ Evet _____ Hayır

Evet ise mesleğiniz: _____

Çocuğunuz var mı?: _____ Evet _____ Hayır

Evet ise kaç çocuğunuz var? _____

Yaşamınızın çoğunun geçtiği yer:

1. Metropol (İstanbul, Ankara, İzmir) 2. Şehir

3. Kasaba 4. Köy

Ekonomik durumunuzu en iyi hangi seçenek yansıtıyor?

Düşük _____

Orta _____

Yüksek _____

Doktor tarafından teşhis edilen herhangi psikolojik bir rahatsızlığınız var mı?

Varsa ne? _____

Doktor tarafından teşhis edilen herhangi fiziksel bir hastalığınız var mı?

Evet ise ne? _____

Doktorlar tarafından teşhis edilmeyen ancak sizde var olduğunu düşündüğünüz psikolojik bir rahatsızlığınız var mı?

_____ Evet _____ Hayır

Varsa ne? _____

Doktorlar tarafından teşhis edilmeyen ancak sizde var olduğunu düşündüğünüz fiziksel bir hastalığınız var mı?

_____ Evet _____ Hayır

Varsa ne? _____

Şu anda herhangi bir nedenle (fiziksel ya da psikolojik) tedavi görüyor musunuz?

_____ Evet _____ Hayır

Evet ise ne? _____

Sağlığınız konusunda ne derecede kaygılı olduğunuzu düşünüyorsunuz?

1. Oldukça kaygılıyım _____ 2. Biraz kaygılıyım _____ 3. Kararsızım _____

4. Kaygılı değilim _____ 5. Hiç kaygılı değilim _____

APPENDIX D: SHORT HEALTH ANXIETY QUESTIONNAIRE (SHAI)

SAĞLIK ANKSİYETESİ ÖLÇEĞİ (KISA VERSİYON)

Bu bölümdeki her soru dört farklı ifade içerir. Lütfen her ifadeyi dikkatlice okuyun ve son 6 ay içindeki duygularınızı en iyi ifade edeni seçin. Seçtiğiniz cümleyi yanındaki harfi daire içine alarak işaretleyin, örneğin (a) cümlesinin doğru olduğunu düşünüyorsanız (a) yı işaretleyin; birden fazla ifadenin size uygun olduğunu düşündüğünüzde size uyan ifadelerin hepsini işaretleyin.

1. (a) Sağlığımla ilgili endişelenmem.
   (b) Sağlığımla ilgili nadiren endişelenirim.
   (c) Sağlığımla ilgili çok sık endişelenirim.
   (d) Sağlığımla ilgili hemen her zaman endişelenirim.

2. (a) Yaşıtlarıma göre daha az ağrı/acı hissederim
   (b) Yaşıtlarım kadar ağrı/acı hissederim
   (c) Yaşıtlarımdan daha fazla ağrı/acı hissederim
   (d) Bedenimde sürekli ağrı/acı hissederim.

3. (a) Genellikle vücudumdaki duyum yada değişikliklerin farkında değilimdir.
   (b) Bazen vücudumdaki duyum yada değişikliklerin farkında olurum.
   (c) Çoğunlukla vücudumdaki duyum yada değişikliklerin farkındayım.
   (d) Sürekli vücudumdaki duyum yada değişikliklerin farkındayım.

4. (a) Hastalıkla ilgili düşüncelere karşı koymak hiçbir zaman sorun olmamıştır.
   (b) Çoğu kez hastalıkla ilgili düşüncelere karşı koyabilirim.
   (c) Hastalıkla ilgili düşüncelere karşı koymaya çalışırım ama çoğunlukla yapamam.
   (d) Hastalıkla ilgili düşünceler o kadar güçlü ki artık onlara karşı hiç koymaya çalışmıyorum.

5. (a) Genellikle ciddi bir hastalığım olduğu korkusu yoktur.
   (b) Bazen ciddi bir hastalığım olduğu korkusu vardır.
   (c) Çoğunlukla ciddi bir hastalığım olduğu korkusu vardır.
   (d) Her zaman ciddi bir hastalığım olduğu korkusu vardır.

6. (a) Kendimi hasta olarak hayal etmem.
   (b) Nadiren hasta olduğum hayalleri gözümün önüne gelir.
   (c) Sıklıkla hasta olduğum hayalleri gözümün önüne gelir.
   (d) Sürekli hasta olduğum hayalleri gözümün önüne gelir.

7. (a) Sağlığımla ilgili düşünceleri zihnimden uzaklaştırmakta zorluk çekmem.
   (b) Sağlığımla ilgili düşünceleri zihnimden uzaklaştırmakta bazen zorlanırım.
   (c) Sağlığımla ilgili düşünceleri zihnimden uzaklaştırmakta çoğunlukla zorlanırım.
   (d) Hiçbir şey zihnimden sağlığımla ilgili düşünceleri uzaklaştıramaz.

8. (a) Doktorum kötü bir şey olmadığını söylerse tamamen rahatlarım.
(b) Başlangıçta rahatlarım ama bazen yeniden endişelenirim.
(c) Başlangıçta rahatlarım ama mutlaka yeniden endişelenirim.
(d) Doktorum kötü bir şey olmadığını söylese de rahatlayamam.

9. (a) Bir hastalık hakkında konuşulduğunda hiçbir zaman kendimde olduğunu düşünmem.
(b) Bir hastalık hakkında konuşulduğunda bazen kendimde de olduğunu düşünürüm.
(c) Bir hastalık hakkında konuşulduğunda çoğunlukla kendimde de olduğunu düşünürüm.
(d) Bir hastalık hakkında konuşulduğunda her zaman kendimde de olduğunu düşünürüm.

10. (a) Vücudumda bir algı ya da değişiklik hissedersem nadiren ne olduğunu merak ederim.
(b) Vücudumda bir algı ya da değişiklik hissedersem çoğunlukla ne olduğunu merak ederim.
(c) Vücudumda bir algı ya da değişiklik hissedersem her zaman ne olduğunu merak ederim.
(d) Vücudumda bir algı ya da değişiklik hissedersem mutlaka ne olduğunu bilmek isterim.

11. (a) Genellikle ciddi bir hastalığa yakalanma riskimin çok düşük olduğunu düşünürüm.
(b) Genellikle ciddi bir hastalığa yakalanma riskimin oldukça düşük olduğunu düşünürüm.
(c) Genellikle ciddi bir hastalığa yakalanma riskimin orta derecede olduğunu düşünürüm.
(d) Genellikle ciddi bir hastalığa yakalanma riskimin yüksek olduğunu düşünürüm.

12. (a) Asla ciddi bir hastalığım olduğunu düşünmem
(b) Bazen ciddi bir hastalığım olduğunu düşünürüm.
(c) Çoğunlukla ciddi bir hastalığım olduğunu düşünürüm.
(d) Genellikle ciddi bir hastalığım olduğunu düşünürüm.

13. (a) Ne olduğu açıklanamayan bir bedensel algı fark edersem başka şeyleri düşünmekte zorlanmam.
(b) Ne olduğu açıklanamayan bir bedensel algı fark edersem başka şeyleri düşünmekte bazen zorlanırım.
(c) Ne olduğu açıklanamayan bir bedensel algı fark edersem başka şeyleri düşünmek çoğunlukla zorlanırım.
(d) Ne olduğu açıklanamayan bir bedensel algı fark edersem başka şeyleri düşünmek her zaman zorlanırım.

14. (a) Ailem ve dostlarım sağlığımla yeterince ilgilenmediğimi söyler.
(b) Ailem ve dostlarım sağlığımla normal düzeyde ilgilendiğimi söyler.
(c) Ailem ve dostlarım sağlığım için fazlaca endişelendiğimi söyler.
(d) Ailem ve dostlarım hastalık hastası olduğumu söyler.

Aşağıdaki soruları yanıtlarken, sizi özellikle rahatsız eden bir hastalığınız (kalp hastalığı, kanser, Multipl Skleroz gibi) olsaydı nasıl olurdu diye düşünün. Tabii ki tam olarak nasıl olacağını bilemezsiniz ama genelde kendiniz ve ciddi bir hastalık konusundaki bilgilerinize dayanarak nasıl olacağı konusunda en iyi tahmini yapmaya çalışın.

15. (a) Ciddi bir hastalığım olsaydı da hayatımdaki şeylerden hala oldukça zevk alabilirdim.
(b) Ciddi bir hastalığım olsaydı da hayatımdaki şeylerden hala biraz zevk alabilirdim.
(c) Ciddi bir hastalığım olsaydı hayatımdaki şeylerden neredeyse hiç zevk alamazdım.
(d) Ciddi bir hastalığım olsaydı hayatımdaki şeylerden hiç zevk alamazdım.

16. (a) Ciddi bir hastalığım olsaydı modern tıbbın beni iyileştirme şansı yüksek olurdu.
(b) Ciddi bir hastalığım olsaydı modern tıbbın beni iyileştirme şansı orta düzeyde olurdu.
(c) Ciddi bir hastalığım olsaydı modern tıbbın beni iyileştirme şansı çok az olurdu.
(d) Ciddi bir hastalığım olsaydı modern tıbbın beni iyileştirme şansı hiç olmazdı.

17. (a) Ciddi bir hastalık yaşamımın bazı alanlarını bozardı.
(b) Ciddi bir hastalık yaşamımın bir çok alanını bozardı.
(c) Ciddi bir hastalık yaşamımın neredeyse her alanını bozardı.
(d) Ciddi bir hastalık yaşamımı mahvederdi.

18. (a) Ciddi bir hastalığım olsaydı onurum zedelenmiş hissetmezdim.
(b) Ciddi bir hastalığım olsaydı onurumu biraz zedelenmiş hissederdim.
(c) Ciddi bir hastalığım olsaydı onurumu oldukça çok zedelenmiş hissederdim.
(d) Ciddi bir hastalığım olsaydı onurumu tamamen kaybetmiş hissederdim.

APPENDIX E: SEMI-STRUCTURED INTERVIEW QUESTIONS

YARI YAPILANDIRILMIŞ GÖRÜŞME SORULARI

1) Kendinizi tanıtır mısınız? (Aile ilişkileri ya da arkadaşlık ilişkileriyle ilgili detaylı bilgi edinilemediği bir durumda, soru detaylandırılacaktır.)
(Could you please introduce yourself? In cases where there is no detailed information about the family or friendship relationships, the question will be elaborated.)
- (Çalışıyor ya da öğrenim görüyor ise) Bu işi/bölümü seçmenizde hangi faktörler etkili olmuştu? *(If he/she is working or studying) What factors influenced your choice of this job / department?)*
-Nasıl bir çocukluk ve ergenlik dönemi geçirdiniz? *(How was your childhood and adolescence period?)*
-Ailenizdeki bireyleri nasıl tanımlarsınız? *(How would you describe the members of your family?)*
-Ailenizdeki bireylerin hastalık konusundaki tutumları nelerdir? *(What are the attitudes of individuals in your family about illnesses?)*
-Yaşadığınız problemlerle nasıl baş edersiniz? (How do you deal with the problems in your life?)
2) Şikâyetlerinizden bahsedebilir misiniz? *(Could you tell me about your complaints?)*
-Şikâyetleriniz ilk ne zaman ortaya çıktı? *(When did your complaints first appear?)*
-Bu zamana kadar ne tür şikâyetleriniz oldu? *(What kind of complaints have you had so far?)*

*Eğer katılımcının almış olduğu bir teşhis var ise bu sorular ek olarak sorulacaktır. *(If the participant has been diagnosed with an illness, these questions will be asked in addition.)*

-Teşhisiniz nedir? Bu teşhis size ne zaman konuldu? Size konulan teşhisi nasıl değerlendiriyorsunuz? (*What's your diagnosis? When did you receive it? How do you evaluate your diagnosis?)*

-Sizi bu teşhis ile kaygılandıran noktalar nelerdir? *(What are your concerns with this diagnosis?)*

3) Hasta olmak sizin için ne anlama geliyor? *(What does being sick mean to you?)*
4) Hasta olduğunuzu hissetmek/hasta olmakla ilgili kaygılanmak sizin için nasıl bir şey? *(What is it like for you to feel sick / worry about being sick?)*
5) Sağlığınızla ilgili bir şikâyetiniz olduğunda nasıl bir yardım arayışına giriyorsunuz? (Soru, doktorları, aile üyelerini, partnerleri ve arkadaşları kapsayacak şekilde ayrıntılandırılacaktır.) *(How do you seek help if you have a complaint about your health? The question will be elaborated to include doctors, family members, partners and friends).*

- Şikâyetlerinizi başkalarıyla ne sıklıkta paylaşıyorsunuz? *(How often do you share your complaints with others?)*

- Kimlerden destek görmeyi talep ediyorsunuz? Kimlerden destek görüyorsunuz? *(From whom do you want to get support? From whom do you get support?)*

- Size yardım edecek kişilerin hangi özelliklere sahip olmasını istersiniz? *(Which characteristics should the people have from whom you expect help?)*

-Bu kişilerle kurduğunuz ilişkiyi nasıl değerlendirirsiniz? *(How do you evaluate your relationship with these people?)*

-Beklediğiniz yardımı/desteği alabiliyor musunuz? Alabildiğinizi ya da alamadığınızı düşündürten sebepler nelerdir? *(Do you take the support you expect? What makes you think you take it or do not?)*

-Doktora hangi şikayetleriniz nedeniyle gidiyorsunuz? *(For what kind of complaints, do you go to the doctors?)*

6) *Vücudunuzda bir sorun olduğunu düşünmeniz/bir sorun olduğuna dair kaygı duymanız konusunda neler düşünüyorsunuz? *(What do you think about thinking / worrying that there is something wrong with your body?)*

   *Bu soru, katılımcılar açısından anlaşılır olmaması nedeniyle soru listesinden çıkartılmıştır. *(This question has been removed from the question list because it is not understandable to the participants.)*

7) Böyle bir kaygınızın olmasının nedenleri sizce neler olabilir? *(In your opinion, what can be the reasons for having such anxiety?)*

8) Bedeniniz sizin için ne anlam ifade ediyor? *(What does your body mean to you?)*

APPENDIX F: CURRICULUM VITAE

PERSONAL INFORMATION

Surname, Name: Bulut, Burcu Pınar
Nationality: Turkish (TC)
Date and Place of Birth: 11 August 1989, Kurşunlu
email: burcupinarbulut@gmail.com

EDUCATION

2012 – 2019	Clinical Psychology Post-Baccalaureate Program Middle East Technical University (TUBITAK 2211 Graduate Scholarship Program)
2010 - 2013	Double Major Undergraduate Program Middle East Technical University Department of Sociology
2007 - 2012	B.S. in Psychology (highest ranked student) Middle East Technical University (TUBITAK 2205 Undergraduate Scholarship Program)

WORK EXPERIENCES

Year	**Place**	**Enrollment**
April 2018- Present	Ankara Hacı Bayram Veli University, Department of Psychology	Research Assistant
March 2014 – April 2018	Middle East Technical University, Department of Psychology	Research Assistant
September 2012 - March 2014	Gazi University, Department of Psychology	Research Assistant

June 2017-Present	Freud Lacan Psychoanalysis Association	Secretary General
September 2016-June 2019	AYNA Clinical Psychology Unit, Department of Psychology, METU	Supervisor
June 2016 –April 2018	AYNA Clinical Psychology Unit, Department of Psychology, METU	Administrative Assistant
September 2013-July 2018	AYNA Clinical Psychology Unit, Department of Psychology, METU	Clinical Psychologist
March 2013-June 2013	Department of Psychiatry at METU Medical Centre	Intern Psychologist
June2010 - August 2010	Department of Psychiatry at Gazi Hospital	Intern Psychologist

PUBLICATIONS

1. **Bulut, B. P.** (2019). Psikanalitik Yönelimli Psikoterapi Seanslarındaki Sessizliğin Konuşma Analizi ile İncelenmesi. *AYNA Klinik Psikoloji Dergisi*, *6*(1), 63-84.

2. **Gökdemir-Bulut, B. P.**, & Bozo, Ö. (2018). The Psychometric Validity and Reliability of the Turkish Version of the Existential Loneliness Questionnaire. *Current Psychology*, 401-413. doi: 10.1007/s12144-016-9534-z

3. **Gökdemir-Bulut, B. P.** (2017). Lacanyen Bakış Açısından Pervert Yapı Kavramı ve Terapötik Öneriler: Vaka Örneği (The Concept of Perverse Structure from Lacanian Perspective and Therapeutic Recommendations: A Case Example). *AYNA Klinik Psikoloji Dergisi*, *4*(1), 26-38.

4. Meunier, B., Atmaca, S., Ayrancı, E., **Gökdemir, B. P.**, Uyar, T., & Baştuğ, G. (2014). Psychometric Properties of the Turkish Version of the Acceptance and Action Questionnaire-II (AAQ-II). *Journal of Evidence-Based Psychotherapies, 14*(2), 179-196.

PRESENTATIONS

International Congresses

1. Demirbaş, H., Bulut, G., & **Gökdemir-Bulut, B. P.** (2017). Childhood Abuse, Suicide Probability and Anger. Oral Presentation at 3rd International Conference on Social Science and Education Research (ICSSER), Roma, Italy.

2. Demirbaş, H., **Gökdemir-Bulut, B. P.,** & Bulut, G. (2017). Exposure to Sibling Abuse and Abusing Siblings: The Moderator Role of Traumatic Life Events. Oral Presentation at 3rd International Conference on Social Science and Education Research (ICSSER), Roma, Italy.

3. **Gökdemir**, **B. P.** & Bozo, Ö. (2015). The factor structure, reliability and validity study of the Turkish version of the Existential Loneliness Questionnaire. Poster Presentation at the 14th European Congress of Psychology, Milan, Italy.

4. Hacıömeroğlu, B., İnözü, M., & **Gökdemir, B. P.** (2015). The association of reassurance seeking with obsessive compulsive symptoms and related emotions. Oral Presentation at the 14th European Congress of Psychology, Milan, Italy. (Research Assistant in the collaboration of The Scientific and Technological Research Council of Turkey (TUBITAK) and Gazi University)

5. Demirbaş, H. & **Gökdemir, B. P.** (2014). How Do the Relationship Between Trait Anger /Anger Expression Styles and Suicide Probability Differ According to Type of Childhood Trauma Experiences? Oral Presentation at XXth ISPCAN International Congress on Child Abuse and Neglect, Nagoya, Japan. (sponsored by The Scientific and Technological Research Council of Turkey (TUBITAK)

National Congresses, Symposiums & Seminars

1. Uçar, S. & **Bulut, B. P.** (2019, May). *Küçük Hans Vakası & Fobi.* Lacanyen Psikanaliz Seminerleri - 2019 Spring, Ankara, Turkey.

2. Aydoğ, S., **Bulut, B. P.**, & Gençöz, T. (2019, April). *Perversiyon.* Lacanyen Psikanaliz Seminerleri - 2019 Spring, Ankara, Turkey.
3. **Bulut, B. P.,** & Özbek Şimşek, D. (2018). *Psikanalizde Klinik Yapılar.* Oral Presentation at 20. Ulusal Psikoloji Kongresi, Ankara, Turkey.

4. **Bulut, B. P.** (2018). *Psikanalitik Açıdan Suça Nasıl Yaklaşılır: Nevrotik, Pervert ve Psikoz Yapının Her Birinde Suç Nasıl Farklılaşıyor?.* 5. Adli Psikoloji, 1. Adli Felsefe, 1. Adli Sosyoloji Kongresi, Gazi University, Ankara, Turkey.

5. Gürsel, D., Gençöz, F., Gençöz, T., Baltacı, S., Ozbek Simsek, D., & **Gökdemir-Bulut, B. P.** (2018, April). *Müzik ve Söylem*. In D. Gürsel (Chair), Lacanyen Psikanaliz Sempozyumu-III: Söylem ve Dil. Symposium conducted by the Freud Lacan Psychoanalysis Association at Turkish-American Association, Ankara.

6. **Bulut, B. P.** (2018, December). *Simgesel, İmgesel, Gerçek.* Lacanyen Psikanaliz Seminerleri - 2018 Fall, Ankara, Turkey.

7. **Bulut, B. P.** & Özbek Şimşek, D. (2018, October). *Psikanalizin Gelişimi ve Freud'a Dönüş*. Lacanyen Psikanaliz Seminerleri - 2018 Fall, Ankara, Turkey.

8. **Bulut, B. P.** (2017, November). *Rüyalar.* Lacanyen Psikanaliz Seminerleri - 2017 Güz, Ankara, Turkey.

9. Baltacı, S., Ozbek Simsek, D., & **Gökdemir- Bulut, B. P.** (2017, May). *Seri Katillerin Isırığı*. In F. Gencöz (Chair), Lacanyen Psikanaliz Sempozyumu-1: Kimlik ve Kimlikleşme. Symposium conducted by the Freud Lacan Psychoanalysis Association at the Middle East Technical University, Ankara.

10. Temizel, S., **Gökdemir-Bulut, B. P.,** Şengül, B. Z., Ünal, E., Akça, S., Suiçmez-Uyar, T., Canel-Çınarbaş, D. (2016, September). *Türkiye halkı ve Suriyeli göçmenlerin gözünden zorunlu göç süreci.* Poster Presentation at 19. Ulusal Psikoloji Kongresi, İzmir, Türkiye.

11. Meunier, B., Atmaca, S., Ayrancı, E., **Gökdemir, B. P.,** Uyar, T., & Baştuğ, G. (2014). *Kabullenme ve Eylem Ölçeği II'nin Türkçe Uyarlama Çalışması ve Psikometrik Özelliklerinin Belirlenmesi*. Poster Presentation at 18. Ulusal Psikoloji Kongresi, Bursa, Turkey.

MANUSCRIPTS IN PREPARATION & UNDER REVIEW

1. Şimşek, D. Ö., **Bulut, B. P.,** Baltacı, S., & Gençöz, F. (under review). Klinikte Lacanyen Psikanaliz. *Türkiye Klinikleri Dergisi, Lacanyen Psikanaliz Özel Sayısı.*

2. Demirbaş, H. & **Bulut, B. P.** (in preparation). *How Do the Relationship Between Trait Anger /Anger Expression Styles and Suicide Probability Differ according to Type of Childhood Trauma Experiences?*

PROJECTS

Obsesif Kompulsif Belirtiler ile Onay Güvence Arama Davranışı OKB ye Özgü İnançlar ve Duygular Arasındaki İlişkinin Klinik Örneklemde İncelenmesi, -Tübitak 3501, Bursiyer, 01/11/2013 - 29/09/2016

TEACHING EXPERIENCES

- Bireysel Ayrılıklar Psikolojisi, Assoc. Prof. Dr. A. Bikem Hacıömeroğlu (Fall, 2019) – Teaching Assistant (Ankara Hacı Bayram Veli University)
- Normal Dışı Davranışlar, Assoc. Prof. Dr. A. Bikem Hacıömeroğlu (Spring, 2018) – Teaching Assistant (Ankara Hacı Bayram Veli University)
- Adult Psychopathology: Psychodynamic Approach, Prof. Dr. Tülin Gençöz (Spring 2018) - Teaching Assistant (METU)
- Behavioral Interventions in Health, Prof. Dr. Özlem Bozo Özen (Spring, 2015; Spring, 2017; Spring, 2018)- Teaching Assistant (METU)
- Health Psychology, Prof. Dr. Özlem Bozo Özen (Fall, 2015; Fall, 2016; Fall, 2017) - Teaching Assistant (METU)
- Emotions in Psychopathology, Prof. Dr. Faruk Gençöz (Spring, 2017)- Teaching Assistant (METU)
- Lacanian Psychoanalysis: Basic Concepts, Prof. Dr. Faruk Gençöz (Fall, 2016) - Teaching Assistant (METU)
- Psychopathology, Assoc. Prof. Dr. Deniz Canel Çınarbaş (Spring, 2015; Spring, 2016)- Teaching Assistant (METU)
- Cultural Issues in Psychotherapy, Assoc. Prof. Dr. Deniz Canel Çınarbaş (Spring, 2016)- Teaching Assistant (METU)
- General Psychology, Prof. Dr. Özlem Bozo Özen (Spring, 2016)- Teaching Assistant (METU)
- Clinical Psychology, Assoc. Prof. Dr. Deniz Canel Çınarbaş (Fall, 2015)- Teaching Assistant (METU)
- Practice of Group Psychotherapy, Assoc. Prof. Dr. Deniz Canel Çınarbaş (Fall, 2015)- Teaching Assistant (METU)

EDITORIAL BOARD

AYNA Klinik Psikoloji Dergisi, *April 2017- Present*

REVIEWER

Ayna Klinik Psikoloji Dergisi
Trafik ve Ulaşım Araştırmaları Dergisi
Kriz Dergisi

FOREIGN LANGUAGES

English (advanced level), French (pre-intermediate level) and German (elementary level)

HOBBIES

Swimming, ballet, music, photography

APPENDIX G: TURKISH SUMMARY/TÜRKÇE ÖZET

BÖLÜM 1

GENEL GİRİŞ

Hipokondriya, zihin-beden problemi çerçevesindeki tartışmaların merkezindedir, çünkü bireylerin “gerçek” bir hastalıkları olmasa dahi fiziksel şikayetleri vardır (Wintrebert, 2009). Zihin ve beden arasında bir etkileşim olduğu, zamanla kabul edilmesine rağmen, çağdaş psikiyatrik tanılama sistemlerinde zihinsel ve fiziksel bozukluklar birbirlerinden ayrıştırılmaktadır.

1.1. Hipokondriya Kavramı

“Hipokondriya” kavramı Antik Yunandan gelmektedir; Hipokrat’ın bir öğrencisi “hipokondrium” bölgesindeki “gerçek” ve acı verici bozukluğu hipokondri olarak adlandırmıştır (Berrios, 2001; Brown, 1936; Grinnell, 2010; Taylor, 2016; Wintrebert, 2009). Bir terim olarak hipokondriyanın anlamı tarihsel süreç içerisinde değişmiştir. Günümüzde bile bu dinamik eski kavramın farklı anlamları bazı ortak özellikler paylaşsa da, kavram belirli bir anlama işaret etmemektedir. Her teorik yaklaşım, hipokondriya kavramını ve ilgili özellikleri kendi bakış açısıyla açıklamaya çalışmaktadır. Bilişsel-davranışçı yaklaşım, bağlanma kuramı yaklaşımı ve psikanalitik yaklaşım yapılan çalışmaya bir temel oluşturması amacıyla ayrıntılandırılmıştır.

1.2. DSM Bakış Açısından Hipokondriya

Bir tanı kategorisi olarak hipokondriyazis uzun zamandır tartışılan bir konudur. Bu tartışmanın bir boyutu hipokondriyazis kategorisinin somatoform bozukluklar kategorisine mi yoksa anksiyete bozuklukları kategorisine mi dahil edilmesi gerektiğidir (Scarella, Laferton, Ahern, Fallon, ve Barsky, 2016). DSM-IV hipokondriyazisi somatoform bozuklukların altında sınıflandırılmıştır ancak bu tanı kategorisi eski ve yanıltıcı bir etimolojiye sahip olduğu ve damgalayıcı çağrışımları olduğu gerekçesiyle DSM-V'ten çıkartılmıştır (Starcevic ve Noyes, 2014). DSM-V'te, bu sınıflandırma sorununa çözüm olarak hipokondriyazisin yerine iki tanı kategorisi eklenmiştir: Şiddetli bedensel şikayetleri olan kişiler için “bedensel belirti bozukluğu” ve hastalıklar konusunda fazlaca kaygılı olan ancak önemli derecede somatik şikayetleri

olmayan kişiler için “hastalık kaygısı bozukluğu” (APA, 2013). Sınıflandırma problemini çözmek amacıyla yapılan bu tür bir ayrım, hem tanı hem de tedavi açısından belirsizlikler taşıması nedeniyle bazı araştırmacılar tarafından eleştirilmektedir (Brakoulias, 2014; Ghanizadeh ve Firoozabadi, 2012). Bu yeni kategoriler çoğu klinisyene yabancı gelmekte; bu nedenle de literatürde “hipokondriazis” ve “sağlık kaygısı” terimleri daha çok tercih edilmektedir. Her ne kadar resmi bir tanı olmasa da sağlık kaygısı, hipokondriazisin duygudurum kısmı ve güvence arayışı gibi hipokondriazis ile ilişkili davranışlar için sıklıkla kullanılmaktadır. Dahası, hipokondriazis genellikle sağlık kaygısının şiddetli bir biçimi olarak anlaşılmaktadır (Starcevic ve Noyes, 2014).

1.3. Bilişsel-Davranışçı Yaklaşım Açısından Hipokondriya

Bilişsel-davranışçı yaklaşıma göre, hipokondriyak bireyler, zararsız fiziksel duyumları fiziksel hastalığın belirtileri olarak sürekli yanlış yorumlar ve bu hipokondriazinin temel özelliğidir. Bireylerin korktukları fiziksel hastalıklar değişkenlik göstermekle birlikte genellikle kanser veya multiple skleroz gibi kronik hastalıklardır (Warwick, 1989). Ayrıca, davranışçı bakış açısına göre, hasta rolü bireye bir avantaj sağlayabilmektedir. Örneğin, birey hasta olması nedeniyle sevdiklerinden daha fazla ilgi ve yardım alabilir veya bazı sorumluluklardan muaf tutulabilir. Semptomların bu tür getirilerine “ikincil kazanç” denilmektedir. Dolayısıyla, bu yaklaşım, hekimlerin ve aile üyelerinin bedensel şikayetlerin sürekliliğindeki rollerini vurgulamakta ve bireylerin bağımsızlıklarını olumlu pekiştirme ile güçlendirmenin önemi üzerinde durmaktadır (Barsky ve Klerman, 1983).

1.4. Bağlanma Teorisi Yaklaşımı Açısından Hipokondriya

Bağlanma kuramı yaklaşımına göre, ebeveynlerle (ya da bakım veren kişilerle) olan çocukluk deneyimleri, içselleştirilen ve yetişkinlik döneminde de devam eden bir dizi ilişki temsillerinin oluşmasına yol açmaktadır (Bowlby, 1969; ayrıca bkz. Hazan ve Shaver, 1987; Wearden, Perryman, ve Ward, 2006). Bağlanma teorisi, sağlık davranışlarının nasıl geliştirildiği ve sürdürüldüğü konusunda kişilerarası ilişkilerin rolünü anlamaya çalışmaktadır (Maunder ve Hunter, 2001). Örneğin Hunter ve Maunder’a (2001) göre, kaygılı bağlanma stiline sahip kişiler, hastalıklarla başa çıkma konusunda kendi yeteneklerine daha az inanmakta, daha fazla bakım ve güvence arayışı içerisinde olmakta ve aynı zamanda da aldıkları güvenceden daha az memnun olma eğilimi göstermektedirler.

1.5. Psikanalitik Yaklaşım Açısından Hipokondriya

Psikanalitik yaklaşım, hipokondriyak belirtileri olan bireylerin ölüm korkularının, belirtilerine sıkı sıkıya tutunmalarının, yardım arama ve reddetme konusundaki davranış kalıplarının ve hastalığı bir savunma mekanizması olarak kullanmalarının üzerine odaklanmaktadır.

Psikanalitik yaklaşımda "beden", hipokondriazisi anlamak açısından önemli bir role sahiptir. Öznenin bedeni ile kurduğu ilişki önceden belirlenmemiştir; yani başlangıçta bedenin psişik bir temsili yoktur (Burgoyne, 2004). Tıbbi yaklaşım ise belirtileri deneyimleyen bedeni biyolojik beden olarak değerlendirir; fakat beden aynı zamanda dil düzenini içinde barındırmaktadır. Bu nedenle, nevrotik bir bireydeki bedensel semptomlar biyolojiyle değil, bireyin kendi biyolojik anatomisini nasıl anlamlandırdığı ile ilişkilidir (Gessert, 2004).

Freud'a göre, hipokondriyazisteki anksiyete ego-libidodan kaynaklanmaktadır (Rosenfeld, 1958; Christogiorgos ve ark., 2013). Freud'a göre hipokondriyak bir birey, libido yatırımını dış nesnelerden geri çekerek bedensel organlarına yapar (vücut organlarının erotikleşmesi). Bu, paradoksal bir şekilde zevk ve acıyı aynı anda içinde barındıran narsist bir yatırımdır (Starcevic ve Lipsitt, 2001, s. 187). Freud'a benzer şekilde Ferenczi ve Schilder, hipokondriyazistte vücudun belirli kısımları için libidoda bir artış olduğunu savunmuşlardır. Travma, libidonun daha önce narsistik anlamda dikkat çeken bir organa transferini kolaylaştırmaktadır (Schilder, 2013, s.143). Bireysel alanın yanı sıra Schilder, kişilerarası etkileşimi, bir kişinin bedenine dair öznel deneyiminin kaynağı olarak vurgulamıştır. Freud'un bakış açısını bir temel olarak kullanan Melanie Klein, hipokondriyi hem narsistik libidodaki bir artış hem de buna karşı yapılan bir mücadele olarak kavramsallaştırmıştır. Çocuğun erken gelişim evreleri ve buna bağlı agresif dürtüler, Kleinian'ın hipokondriyaya yaklaşımında merkezi bir konumdadır. Herbert Rosenfeld (1958), Freud ve Klein'ın, erken dönem narsistik evreye bir gerileme olduğu yönündeki fikrine katılmıştır. Bununla beraber hipokondriyanın geçici veya kronik olup olmamasına göre farklılaştırılması gerektiğini de eklemiştir. Katzenegelbogen (1942), psikotik olmayan kişilerin hipokondriyak şikayetlerini somatik içerikli psikotik sanrılardan ayırt edebilmek için psikotik olmayan bireylerin bedensel şikayetleri için "hipokondri" yerine "somatik" ifadesinin kullanılmasını önermiştir.

Hipokondriya literatürüne bir başka katkı Charles William Wahl tarafından yapılmıştır. Wahl, hipokondriyak bireylerin semptomlarına bağlılıklarının arkasında doktorun yardım denemelerini agresif bir şekilde reddetme amacı olmadığını, semptomlarının bir soruna çözüm olması dolayısıyla bu kişilerin "iyi hissetme"ye yönelik isteksiz olduklarını söylemiştir. Dahası, Wahl'a göre, hipokondriyak bireyler fiziksel şikayetlerin ve hastalıkların çokça konuşulduğu

ailelerde yetişmişlerdir. Özdeşim kurma süreçleri nedeniyle, böyle bir ailede yetişen çocuk, ebeveyn figürünün kırılganlığı ile özdeşleşmektedir. Ayrıca Wahl, hasta olmanın bilinç dışı olarak kişiye bakım alma ve şefkat görme gibi faydalar sağladığını ikincil kazanç kavramıyla açıklamıştır. Hastanın hayatındaki ikincil kazançları bulmak için, yaşamının yakından incelenmesi gerekmektedir (Wahl, 1963).

Psikanalitik literatürde "hipokondriya" belirsiz yönleri olan bir kavram olmaya devam etmektedir. Hipokondriya, izole bir nevroz gibi görünmekten ziyade akut anksiyete nevrozu, nevrasteni veya zorlantı nevrozları gibi diğer psikopatolojilerle biraradalık (komorbidite) gösterir. Hem nevrotik hem de psikotik yapıların izlerini taşıdığı için hipokondriya, histeri ve psikoz arasında bir geçiş aşaması olarak bile kabul edilmektedir (Fenichel, 2005, s. 240).

1.6. Çalışmanın Amacı

Araştırmacı, klinik psikolog olması nedeniyle profesyonel anlamda çeşitli somatik şikayetleri olan kişilerle karşılaşmaktadır. Bu tür şikayetler aynı zamanda araştırmacının ailesinde de yaygındır; dolayısıyla günlük yaşamının bir parçası halindedir. Hipokondriyak semptomları olan bireylerin bedensel semptomlarına saplanma halleri ve sağlıkları için endişelenmemeye ikna edilme konusundaki zorlukları araştırmacının özellikle dikkatini çekmiştir. Dahası, araştırmacının teorik yaklaşımı, aktarımın önemli bir kavram olduğu Lacanyen psikanalizi temel almaktadır. Hipokondriyak bireyler, önemli başkalarından ve sağlık profesyonellerinden güvence alma istekleri ve aynı zamanda aldıkları güvenceyi reddetmeleri ile bilinmektedir. Bu nedenle araştırmacı, hipokondriyak bireylerle kurulan aktarım ilişkisinin çalışılmasının, hasta ile terapist arasındaki ilişkinin tüm tekniklerden daha önemli bir konumda olduğu psikoterapiler için yararlı olabileceğini düşünmektedir.

Bu çalışmada, sağlık kaygısı yüksek olan bireylerin bedenleriyle nasıl ilişki kurduklarını, kendilerinde var olduğuna inandıkları (ya da teşhis edildikleri) hastalıklarına veya hastalığa ilişkin kaygılarına dair deneyimlerini araştırmak amaçlanmıştır. Ayrıca, bu kişilerin özellikle doktorlarla, diğer sağlık profesyonelleriyle ve güvence aramak için başvurdukları başkalarıyla ilişki kurma şekilleri anlaşılmaya çalışılmıştır. Çalışmanın hedefi istatistiksel bir genelleme yapmak değildir; aksine, bu kişilerin şikayetlerini nasıl yorumladıklarını, bu konu hakkındaki duygularının ve düşüncelerinin neler olduğunu ve belirtilerinin kendilerini nasıl etkilediğini ve tüm bunları nasıl ifade ettiklerini derinlemesine anlamak araştırmacının odak noktalarıdır.

BÖLÜM 2

YÖNTEM

2.1. Nitel Araştırma Yöntemi ve Yorumlayıcı Fenomenolojik Analiz

Nitel araştırmaların amacı, katılımcıların sosyal fenomenleri nasıl anlamlandırdıkları, algıladıkları ve deneyimledikleri üzerinde durarak bu fenomenlere açıklık kazandıracak kavramların geliştirilmesine katkıda bulunmaktır (Pope ve Mays, 1995). Hipokondriyak semptomları olan bireylerle çalışan klinisyenlere ve hekimlere, semptomların tarihçesini ve seyrini dikkatlice değerlendirmeleri ve kişilerin etkileşim tarzlarına, semptomlarını tanımlarkenki dil kullanımlarına ve bedenleriyle nasıl ilişki kurduklarına önem göstermeleri tavsiye edilmektedir (Lipsitt, 2015). Pratik uygulamalara katkıda bulunmak için bu alanları kapsayacak araştırmalar yapılması gerekmektedir ve nitel yöntem bu amaca uygundur.

Yorumlayıcı fenomenolojik analiz (YFA), köklerini fenomenolojiden, hermeneutikten (yorum bilgisi) ve idiografiden (spesifik bir olayı anlamaya yönelik) almaktadır (Smith, 2011, s. 9.). Husserl'in felsefi çalışması fenomenolojinin temelini oluşturmaktadır. Husserl'e göre, bir fenomeni anlamak için öznel deneyimin zengin bir şekilde tasvir edilmesi gerekmektedir. Martin Heidegger de fenomenolojik yaklaşımında öznel deneyimlerle ilgilenmiştir; ancak tasvir etme yerine yorumlamaya daha çok önem vermiştir (Dowling, 2007). Heidegger'in hermeneutik fenomenolojisi temel alındığında, YFA'da, kişilerinin deneyimlerinin araştırmacı tarafından yorumlanması, bu deneyimlere erişmek için gerekli bir süreçtir (Smith ve Osborn, 2003; Smith, 2011; Biggerstaff ve Thompson, 2008). YFA, bir kişinin kendi deneyimlerine nasıl bir anlam verdiğine odaklandığı için (Willig, 2001), vakanın çok ayrıntılı bir incelemesinin yapılarak öznel deneyimlerinin çalışılabilmesine sistematik bir yaklaşım sunmaktadır (Smith, Harre ve Van Langenhove, 1995). Sağlıkla ilgili konular için YFA, sık kullanılan bir yöntemdir (Cronin ve Lowes, 2016); çünkü sağlık uzmanlarına hastalıkları (bu çalışmada fizyolojik bir boyuta sahip psikolojik bir durum) hastanın gözünden görme olanağını sağlamaktadır (Biggerstaff ve Thompson, 2008).

2.2. Katılımcılar ve Örnekleme Yöntemi

Katılımcıların yaş aralıkları, yaşadıkları şehir ve sağlık kaygılarının seviyeleri YFA'nın amaçlı örnekleme yöntemine uygun olarak gereken homojenliği sağlamak için sınırlandırılmıştır

(Smith ve Osborn, 2003). Buna göre, çalışmanın katılımcıları; 19-55 yaşları arasında, Ankara'da yaşayan, anket puanlarına göre sağlık kaygıları yüksek olan ve sağlık kaygıları olduğu kendileri tarafından da rapor edilen 14 kişiden oluşmaktadır.

YFA'da örneklem büyüklüğü belirlenirken belirli bir kuraldan çok çeşitli ilkeler göz önünde bulundurulmaktadır. Bu araştırmanın örneklem büyüklüğü belirlenirken; çalışmanın amacı ve yapılan görüşmelerden araştırılan fenomene dair elde edilen bilgilerin ne kadar zengin olduğu dikkate alınmıştır. YFA'da vakaların derinlemesine analiz edilmesi amaç olduğu için genellikle örneklemin küçük tutulması tercih edilmektedir (Smith ve Osborn, 2003). Sonuç olarak, bu çalışmanın örneklem büyüklüğü YFA için uygundur.

2.3. İşlem

Çalışmanın yürütülebilmesi için gereken etik onay, Orta Doğu Teknik Üniversitesi İnsan Araştırmaları Etik Kurulundan alınmıştır. Bilgilendirilmiş onam formu, demografik bilgi formu ve Sağlık Anksiyetesi Ölçeği potansiyel katılımcıların çoğuna e-posta yoluyla iletilmiştir. Pratik nedenlerden ötürü, üç katılımcıya anketler basılı kopya olarak verilmiştir. Potansiyel katılımcılardan anket verileri toplandıktan sonra, görüşme yapılması uygun olan katılımcılar belirlenmiştir. Çalışmanın verileri, yüz yüze yarı yapılandırılmış görüşmeler yoluyla elde edilmiştir. Araştırmacı, bir yandan hazırladığı görüşme sorularını akılda tutarken, bir yandan da görüşme esnasında ortaya çıkan yeni konulara açık olmaya ve katılımcılara özgürce konuşabilecekleri bir ortam sağlamaya çalışmıştır. Her bir katılımcıyla yalnızca bir kez görüşülmüştür. Görüşmeler ses kayıt cihazı ile kaydedilmiş ve katılımcılar onam formunda bu konuda önceden bilgilendirilmişlerdir. Görüşmeler 50 dakika ile 2 saat arasında sürmüştür. Gizliliklerini koruyabilmek amacıyla gerçek isimlerinin yerine katılımcılara takma isimler verilmiştir. Çalışmanın yürütüldüğü dönemde profesyonel destek almayan katılımcılara, yapılan görüşmenin sonunda bir uzmana yönlendirilmek isteyip istemedikleri sorulmuştur. İsteyen katılımcılara Orta Doğu Teknik Üniversitesi Psikoloji Bölümüne bağlı olarak çalışmalarını yürüten AYNA Klinik Psikoloji Destek Ünitesi hakkında bilgi verilmiştir.

2.4. Veri Analizi

Analizler YFA'nın ilkelerine göre yapılmıştır (Smith ve Osborn, 2003). YFA'nın felsefesi fenomenoloji ve idiografiye dayanmaktadır (Smith, Flowers, ve Larkin, 2009); bu nedenle, daha genel kategorilere ulaşmadan önce her bir vakanın ayrı ayrı analiz edilmesi ve ayrıntılı incelenmesi gerekmektedir. İlk olarak, birinci görüşmenin ses kayıtları deşifre edilmiştir. Deşifre edilen bu metin, katılımcı hakkında bütünsel bir fikir edinebilmek için birkaç kez

okunmuştur. Araştırmacı tarafından bu okumalar yapılırken deşifre metinlerinin sol kenarına araştırmacının yorum ve düşüncelerini de içeren bazı notlar yazılmıştır. Daha sonra ilk notlar, geçici temalara dönüştürülmüş ve bu temalar sağ kenara not edilmiştir. Bir sonraki adım olarak, bu temaların bağlantıları incelenmiş ve ilgili olanlar alt ve üst temaları elde etmek için kümelenmiştir. Birinci vaka için alt ve üst temalar oluşturulduktan sonra, her vaka için aynı işlem tekrarlanmıştır. Yapılan analizler sonucunda, 'Sağlık kaygısına yapılan nedensel atıflar: Halledilmemiş bir mesele olarak kayıp', 'Semptomun girbadına sürüklenmek', 'Deneyimlerini adlandırması ve belirsizliği ortadan kaldırması için bir uzmana yapılan sonsuz çağrı' ve 'Her şerde bir hayır vardır: Hasta olmanın/hasta hissetmenin faydaları' olmak üzere dört tema ortaya çıkmıştır.

2.5. Çalışmanın Güvenirliği

YFA yaklaşımında, araştırmacının katılımcıların yorumlarına ilişkin değerlendirmelerinin önemi vurgulanarak, araştırmacının konuya dair ön bir anlayışı olduğu kabul edilmiştir. Bu kabul ile birlikte, çalışmanın güvenirliği için araştırmacının kendi inançlarını, değerlerini, bilgi ve deneyimlerini tanıması ve bunların farkında olması önemlidir; çünkü bunlar tüm araştırma sürecini etkileyebilmektedir. Bu bağlamda, araştırmacının teorik yaklaşımını ve bu tezin konusu ile ilgili olarak kişisel deneyimlerini açıklaması önemli olmaktadır. Araştırmacı 30 yaşında bir kadındır ve ODTÜ'de Klinik Psikoloji alanında doktora yapmaktadır. Üç buçuk yıldır Lacanyen Psikanaliz üzerine çalışmaktadır. Bu nedenle, psikolojik kavramlara ve psikopatolojiye bakış açısı, Lacanyen yaklaşımdan etkilenmiştir. Hipokondriyayı bir teşhis olmaktan ziyade daha genel bir yapı içerisinde tartışılabilecek bir semptom olarak düşünmesi, katılımcıların hipokondriya teşhisi almış olup olmamalarını önceliği olmaktan çıkartmasına neden olmuştur. Teorik bakış açısının yanı sıra, sağlık kaygısı olan bireyler araştırmacının kişisel yaşamımın da önemli bir parçasıdır. Aile bireyleri arasında sağlık kaygısı ve genel olarak da kaygı yaygın bir durumdur.

Araştırmacının kişisel bakış açısının araştırma süreci üzerindeki olası etkilerinin farkında olmasının yanı sıra, yarı yapılandırılmış yüz yüze görüşmeler yoluyla veri toplamak araştırmanın güvenirliğini artırmak için önerilen başka bir stratejidir (Chan, Fung, ve Chien, 2013). Görüşmelerin yarı yapılandırılmış yapısı, araştırmacının katılımcıları odaklı bir şekilde dinlemesine ve önceden hazırlanmış sorularla sınırlı kalmadan, katılımcının getirdiği konular hakkında konuşmalarına olanak sağlamaktadır. Ayrıca, Chan ve arkadaşları tarafından önerildiği gibi, veri toplama ve görüşmelerin değerlendirilmesi süreci boyunca merakı koruyabilmek ve yeni fikirlere açık olabilmek adına literatür taraması yapmaktan geri durulmuştur. Ayrıca, tema oluşturma sürecinde, katılımcılarla yapılan görüşmelere ait deşifre

metinleri üzerinde yapılan ilk yorumlamalar tez danışmanı ile birlikte değerlendirilmiş ve daha sonra ortaya çıkan temalar o temalarla ilişkilendirilen katılımcıların alıntılarıyla, araştırma sürecini daha açık hale getirmek için bir araştırma ekibi ile birlikte tartışılmıştır.

BÖLÜM 3

SONUÇLAR/BULGULAR

14 vakanın yorumlayıcı fenomenolojik analiz yöntemiyle analiz edilmesi sonucunda, dört üst tema ortaya çıkmıştır: İlk tema 'Sağlık kaygısına yapılan nedensel atıflar: ‘Halledilmemiş bir mesele olarak kayıp'; ikinci tema 'Semptomun girbadına sürüklenmek’; üçüncü tema ‘Deneyimlerini adlandırması ve belirsizliği ortadan kaldırması için bir uzmana yapılan sonsuz çağrı' ve dördüncü tema, 'Her şerde bir hayır vardır: Hasta olmanın/hasta hissetmenin faydaları'dır.

3.2.1. Sağlık Kaygısına Yapılan Nedensel Atıflar: Halledilmemiş Bir Mesele Olarak Kayıp

Tüm katılımcılara, sağlık kaygılarının başlangıcına hangi etmenlerin katkısı olduğunu anlamak için kaygılarının ne zaman ve nasıl başladığı ile hangi durumlarda bu şikayetlerinin arttığı sorulmuştur. Kaygılı bir ebeveyn figürüne sahip olmak katılımcılar tarafından ifade edilen temel etmenlerden birisi olmuştur. Katılımcılar ebeveynlerini (anne ve babalarının her ikisini ya da anne veya babalarından birini) spesifik olarak sağlık konusunda ya da genel anlamda her konuda endişeli kişiler olarak tanımlamışlardır. Kaygının bir nesilden diğerine aktarılmasına yapılan vurgu bazen o kadar kuvvetli olmuştur ki; bu, katılımcıların kendilerindeki kaygıyı aile bireylerinden “genetik” bir geçiş olarak yorumladıkları düşünülmüştür. Bir nesilden diğerine olan bu aktarımın aslında ‘halledilmemiş bir mesele olarak kalan kayıpla’ ilgili kaygının iletilmesi olduğu değerlendirilmiştir. Bazı katılımcılar ise sağlık kaygılarına özgü olmasa bile kayglı olmak konusunda bir yatkınlıklarının olduğunu belirtmişlerdir. Kaygılı bir ebevyn figürüne sahip olmaya ve kaygıya eğilimli olmaya ek olarak, katılımcıların çoğu sağlıkla ilgili kaygılarının ortaya çıkmasını; bir kaybı deneyimlemiş, gözlemlemiş ve / veya beklentisi içerisine girmiş olmakla ve bu deneyimlerle ilgili yaşadıkları zorluklarla ilişkilendirmişlerdir. Hastalık deneyimini kendileri yaşayan katılımcılar, sağlık kaygılarını hastalığın kendisi veya hastalıklarıyla ilgili deneyimledikleri prosedürlerle ilişkilendirmişlerdir. Katılımcılar, hastalık ve

anksiyete arasındaki ilişkiyi sadece hayatlarını kaybetme ihtimalleri üzerinden değil aynı zamanda bağımsızlıklarını, güçlerini ve saygınlıklarını kaybetme olasılıkları üzerinden de kurmuşladır.

3.2.2. Semptomun Girbadına Sürüklenmek

Görüşmeler sırasında, katılımcılar şikayet ettikleri veya korktukları şeylerin daha da içine girmekten kendilerini nasıl geri alamadıklarını ifade etmişlerdir. Elde edilen sonuçlara göre, sağlıkla ilgili kariyer seçimi ya da bu tip bir kariyer seçmemiş olsalar bile bu yönde bir seçim yapma isteği katılımcılar tarafından dile getirilmiştir. Katılımcıların sağlıkla ilgili kariyer seçimlerine ek olarak ortaya çıkan diğer bir alt tema, bedeni en ufak değişiklikleri bile görebilecek bir biçimde incelemeyi, semptomlar hakkında bilgi almak ve kontrol etmek için internet taraması yapmayı, sağlık durumunu gözden geçirmesi için sık sık doktora gitmeyi ve beslenme gibi yaşam tarzı alışkanlıklarına abartılı bir şekilde dikkat etmeyi içeren tedbir davranışlarıyla meşgul olmaktır. Ancak bu davranışlar bazen ters etki oluşturan sonuçlara yol açmaktadır: Katılımcıların kaygı düzeyleri azalmak yerine artmaktadır. Ayrıca katılımcılar internet kaynaklarının hastalıklar konusunda karamsar bir bakış açısına sahip olduğunu bilmelerine rağmen, semptomları hakkında daha fazla bilgi edinmek için bunu yaptıklarını ifade etmişlerdir. Son olarak, bazı katılımcılar gelecekte ortaya çıkabilecek hastalık veya ölüm gibi kötü olaylar üzerine fazlaca düşündüklerini söylemişlerdir.

Katılımcıların seçimleri, davranışları ve düşünceleri, onları semptomun daha da içine girmeleriyle sonuçlanması bakımından çelişkili görünmektedir. Bu durumu nasıl yorumladıklarını anlamak için sorular sorulduğunda, katılımcılar zaman zaman neden böyle olduğunu anlamadıklarını ve bilmediklerini söylemişlerdir. Ancak katılımcıların ifadelerine göre temel neden, endişelendikleri şeyler üzerinde daha da içine girerek bir hakimiyet kurma çabasıdır. Sağlık kaygısı üzerindeki kontrolü sürdürme çabalarının çoğu zaman işe yaramadığını ve hatta daha da kaygılandıklarını ifade etmelerine rağmen, bunu yapmayı durduramadıklarını belirtmişlerdir.

3.2.3. Deneyimlerini Adlandırması ve Belirsizliği Ortadan Kaldırması için Bir Uzmana Yapılan Sonsuz Çağrı

Çalışmanın bir diğer amacı, sağlık kaygısı olan bireylerin sağlık hizmeti veren profesyonel kişilerle nasıl etkileşime girdiklerini, onlardan neler beklediklerini anlamaktır; çünkü sıklıkla ve bazen de takıntılı bir şekilde sağlık kaygısı olan bireyler bu profesyonellerle yüz yüze gelmektedirler. Bu amaçla, katılımcılara sağlık profesyonelleriyle kurdukları ilişkiyi anlamaya

ve onlardan beklentilerinin ne olduğuna yönelik sorular sorulmuştur. Elde edilen yanıtlar, katılımcıların deneyimlerini adlandırarak bunları kendileri için anlamlı hale getirebilmeleri ve sağlık durumlarıyla ilgili şüphelerini ortadan kaldırmaları için doktorlara ihtiyaç duyduklarını göstermektedir; ancak bilgi ve netlik kazanma ihtiyacı doktordan bakım talep etmekten bağımsız olarak ifade edilen bir şey olmamıştır. Şöyle ki, katılımcılar için doktorun yalnızca bilgili olması, "iyi bir doktor" olması için yeterli görünmemekte aynı zamanda onların ilgili olmasını ve kendilerine özenli ve ilgili davranmalarını beklemektedirler. Ancak beklentilerinin belirsizliği veya hastalık ve ölümle ilgili konuların belirsiz bir doğaya sahip olması nedeniyle beklentileri karşılanmamakta veya karşılansa bile yalnızca geçici olmaktadır. Sonuç olarak, katılımcıların çoğu, doktorlar tarafından anlaşılmadıklarından ve yeterince özen gösterilmediklerinden şikayet etmektedirler.

Aslında, zaman zaman katılımcıların doktorlardan beklentileri olarak dile getirdikleri şeyler daha yakın ilişki kurulan birisinden beklenecek türden şeyler olmuştur. Görüşmeler sırasında bazı katılımcılar -araştırmacı da dahil olmak üzere- sağlık profesyonellerinden bu tür taleplerini ifade etmişlerdir. Örneğin bir katılımcı, araştırmacıya kendisini doktora götürmesi ve kendisi adına yaşadığı sağlık sorunlarını açıklaması konusunda bir talepte bulunmuştur. Bu şekilde, doktorlar tarafından daha iyi anlaşılacağını düşündüğünü belirtmiştir.

Görüşmeler sırasında bazı katılımcıların kaygılarını ve sağlık sorunlarını yansıtmak için kullanıldıkları ifade stilleri bir başka önemli noktayı ortaya koymuştur. Bazı katılımcılar, yaşadıkları sıkıntılarını aktarırken "*İnan abartıyor diye düşünme*", "*İnan ki"*, *"Gerçekten"* gibi ifadeler kullanmışlardır. Bir kelimeyi tekrar tekrar söylemek de bu iletişim tarzıyla ilgili olduğu düşünülen bir başka ifade tarzı olmuştur. Bu tip sözlü ifadelere ek olarak, bir katılımcının görüşme odasındaki davranışsal gösterimleri dikkat çekici olarak değerlendirilmiştir. Örneğin, bu katılımcı görüşme sırasında ayağa kalkmış ve acı çekerken nasıl yerinde duramadığını göstermek için odada gezinmiştir. Bu iletişim tarzının amacının, semptomlarının doğruluğunu vurgulamak, karşılarındaki kişiyi onlarla yaşamanın ne kadar zor olduğuna ikna etmek ve onlara bir çağrı yapmak olduğu düşünülmüştür. Doktorlar da sağlık kaygısı yaşayan bu bireylerin, kendilerinde neyin yanlış olduğunu anlamak için çağrıda bulundukları kişilerin başındaymış gibi görünmektedir.

3.2.4. Her Şerde Bir Hayır Vardır: Hasta Olmanın/Hasta Hissetmenin Faydaları

Katılımcıların hemen hepsi hasta olmanın ya da hasta hissetmenin beraberinde getirdiği olumsuzluklar olmasına rağmen olumlu taraflarından bahsetmişlerdir. Bazı kazanımlar katılımcılar tarafından açıkça vurgulanırken, bazı kazanımlarsa katılımcıların ifadelerinden

çıkarım yapılarak elde edilmiştir. İlk gözlenen kazanım hastalık ya da hasta hissetme nedeniyle başkalarından ilgi veya bakım almak olmuştur. Bakım ve ilginin kaynağı; kişilerin çocukları, ebeveynleri, partnerleri veya doktorlar olabilmektedir.

Görüşmelerde bazı katılımcılar sağlık kaygılarının, ilişkilerinde veya işlerinde bir sorun yaşadıklarında ortaya çıktığını ve yaşadıkları sorunları ortadan kalktıktan hemen sonra sağlık durumlarının ilginç bir şekilde düzeldiğini belirtmişlerdir. Katılımcıların bu tür ifadeleri araştırmacının sağlık kaygısındaki bu artışın nedenleri ve işlevlerinin neler olabileceği hakkında düşünmesini sağlamıştır. Bu bakımdan sağlık kaygısının, diğer yaşam zorluklarıyla başa çıkma mekanizması olabileceği düşünülmüştür.

Hasta olmanın ya da hasta hissetmenin bir başka getirisi de sorumlulukların ve önceliklerin yeniden düzenlenmesi ve sağlığa her şeyden daha yüksek bir öncelik verilmesi olarak ortaya çıkmıştır. Sonuç olarak, katılımcıların öz bakımlarında, kendilerini kabul etmelerinde ve kendilerine verdikleri değerde bir artış olmuş, suçluluk duygularında ise bir azalma gerçekleşmiştir.

BÖLÜM 4

TARTIŞMA

Bu çalışmanın amacı, aynı zamanda hipokondriyak olarak da bilinen sağlık kaygısı olan bireylerin; şikayetlerini, sağlık sorunları ile ilgili deneyimlerinin ne olduğunu ve sağlık hizmeti veren profesyonelleriyle ve yakın ilişki kurdukları kişilerle nasıl etkileşime girdiklerini anlamaya çalışmaktır. Bu amaçla, sağlık kaygısı yüksek olan kişiler ile görüşülmüş ve görüşmelerin deşifre metinleri yorumlayıcı fenomenolojik analiz yöntemiyle analiz edilmiştir. Sonuç olarak ortaya çıkan dört tema aşağıda tartışılmıştır.

4.1. Sağlık Kaygısına Yapılan Nedensel Atıflar: Halledilmemiş Bir Mesele Olarak Kayıp

Sağlık kaygısının ortaya çıkmasıyla ilgili olarak, katılımcılar kaygılı olmaya yatkın olduklarını, ebeveynlerinden en az birinin kaygılı olduğunu ve sağlıklarına odaklanmalarına neden olan bir

olay yaşadıklarını ifade etmişlerdir. Katılımcılar, sağlık kaygılarının olmasını bunlardan yalnızca birisiyle açıklamak yerine, bu etmenlerin bir araya gelmesiyle açıklamışlardır. Bu durum, psikiyatrik bozuklukların temelinde yatkınlığın ve stresli bir deneyim yaşamanın bir araya gelerek birikmesinin ya da bir arada bulunuşunun olduğunu ileri süren stres-yatkınlık modelini destekliyor gibi görünmektedir (Russo, Vitaliano, Brewer, Katon, ve Becker, 1995).

Neredeyse tüm katılımcılar, ebeveynlerinden en az birisini kaygılı bir insan olarak tanımlamışlardır. Bu bulgu, çocukların ebeveynleriyle yaşadıkları deneyimlere dayanarak ilişki temsiliyetleri oluşturduklarını öne süren bağlanma kuramının bakış açısına uymaktadır (Bowlby, 1969). Kaygılı ebeveyn- kaygılı çocuk örüntüsü başka bir bakış açısından daha ele alınabilir. Şöyle ki; bu örüntü, Wahl'ın (1963) fiziksel şikayetleri ve hastalıkları üzerine fazlaca konuşan ebeveynlere sahip olan çocukların ebeveynleriyle özdeşim kurmaları olarak ifade ettiği mekanizmayla da açıklanabilmektedir. Katılımcıların ifadelerine bakıldığında, ailedeki kaygılı bir ebeveynin çocuklar üzerinde iki zıt etkisinin olduğu görülmektedir: Çok kaygılı bir çocuk veya çok duyarsız bir çocuk. Katılımcılara kardeşlerinin sağlıkla ilgili konularda nasıl davrandıkları sorulduğunda, kız kardeşlerinin ya da erkek kardeşlerinin ya çok kaygılı olduklarını (özellikle sağlık konusunda olmasalar bile) ya da hastalıklarla ilgili olarak hiç kaygı duymadıklarını söylemişlerdir. Kaygılı bir ebeveynin kaygılı olmayan hatta umursamaz derecesinde rahat olarak tarif edilen çocuklarının olmasını, karşıt tepki oluşturma mekanizmasıyla açıklamak mümkün olabilir. Karşı fobiye benzer bir işleyiş şekliyle, kayıtsız tavrın, kaygıya karşı bir çeşit savunma mekanizması olabileceği düşünülmektedir.

Ayrıca, çalışmanın sonuç bölümünde açıklandığı gibi, katılımcıların sağlık kaygılarının ortaya çıkışıyla ilgili olarak söyledikleri, semptomlarının kayıpla ilgili çözülmemiş meselelerle ilgili olduğuna işaret etmektedir. Kaybın bir boyutunu "yaşamını kaybetmek" oluşturmaktadır. Birçok katılımcı hastalığı ölümle eşleştirdiğini söylemiş ve hatta bazı katılımcılar ölüm kaygılarının sağlık kaygılarından daha önce ortaya çıktığını belirtmiştir. Literatür, hastalıklardan korkma ile ölüm korkusu arasında bir bağ olduğunu desteklemektedir. Örneğin, bir meta-analiz çalışması, ölüm kaygısı ve hipokondriya arasında pozitif bir ilişki olduğunu göstermiştir (Stegge, Tak, Rosmalen, ve Voshaar, 2018). Ölüm korkusu; terör yönetimi kuramı ya da bilişsel-davranışçı kuram gibi çeşitli yaklaşımlar tarafından hipokondrinin gelişiminin, seyrinin ve devamlılığının altında yatan temel bir korku olarak tartışılmaktadır (Arndt, Routledge, Cox, ve Goldenberg, 2005; Furer ve Walker, 2008; Strachan ve ark., 2007). Bazı katılımcıların sağlık kaygıları; meme, yumurtalık veya genital bölge gibi üreme alanlarına odaklanmıştır. İnsanların ölümleriyle yüzleşmelerini sağlayan sembolik ölümsüzlüğü elde etmenin bir yolu olan biyolojik mod, bir kişinin üreme yoluyla neslinin devamlılığını sağlayarak ölümüyle başa çıkma durumunu tanımlamaktadır (Florian ve Mikulincer, 1998). Dolayısıyla

katılımcıların kaygılarının bu alanlara odaklanmış olmasını, ölüm fikriyle başa çıkmanın zorluğuyla ve aynı zamanda da sembolik ölümsüzlüğü sağlayan biyolojik modun zarar göreceği düşüncesiyle ilgili olarak düşünmek mümkündür.

Kayıp yalnızca yaşamın ve sağlığın kaybı alanlarını içermez. Kayıp ayrıca ayrışma meseleleriyle de ilişkili görünmektedir. Katılımcılar için hastalığın ve sağlığını kaybetmenin ne anlama geldiğine bakıldığında hasta olmanın; gücün, itibarın, bağımsızlığın, yaşamın ve sevilen kişilerin kaybı ile ilişkilendirildiği ortaya çıkmıştır. Katılımcılar sağlık kaygılarını anlatırken, hastalık korkusu, ölüm korkusu ve ayrışma korkusu iç içe geçmiş bir şekildedir. Katılımcıların ifadelerini göz önüne alarak, bir kişinin yaşamını, sağlığını veya ilişkisini kaybetme korkusunun olmasını; ölüm, hastalık veya ayrılıkla ilgili olarak kayıpla nasıl başa çıkacağını bilememesinin bir yansıması olarak düşünmek mümkündür. Freud'a göre ölüm korkusu, tehlikeyle başa çıkamama duygusundan ve koruyucu hiç bir kuvvetin olmamasından kaynaklanmakta; bu nedenle bedensel egonun bütünlüğü tehdit altında bulunmaktadır (Wilton, 2003). Çalışmanın konuya ilişkin bulguları Freud'un bu görüşünü destekler niteliktedir.

4.2. Semptomun Girbadına Sürüklenmek ve Deneyimlerini Adlandırması ve Belirsizliği Ortadan Kaldırması için Bir Uzmana Yapılan Sonsuz Çağrı

Katılımcıların sağlık sektörüyle ilgili bir kariyer seçmiş olmaları, sağlık kaygıları etrafında şekillenen düşünce ve davranışları, sağlık kaygısının bu kişilerin yaşamlarındaki merkezi konumunu göstermektedir. Sağlık kaygısı ile bu türden bir meşguliyet, birçok farklı teorik yaklaşımda hipokondriyanın önemli bir özelliği olarak vurgulanmaktadır; hatta bu özelliğe hipokondriyanın tanımı içerisinde yer verilmektedir (Baur, 1989). Katılımcıların ifadeleri, semptomun daha da içine girmenin en önemli nedeninin bunun üzerinde kontrol etme çabası olduğuna işaret etmektedir. Semptomlar ve hastalıkların tedavisi hakkında bilgi sahibi olmak, hastalıkları önlemek için sağlığa dikkat etmek, gelecekte meydana gelebilecek kötü şeyler üzerinde düşünmek ve bunu yaparak olası kötü şeyler için önceden hazırlık yapmak ve bir hastalık durumunda doktorların yardım edebileceği şekilde hastanelere yakın olmak bu kontrol altına alma çabasının önemli bileşenlerini oluşturmaktadır.

Bununla birlikte, katılımcılar semptomları hakkında daha fazla bilgiye sahip olmanın ve sağlık durumlarını kontrol etmeye çalışmanın kendileri üzerinde iki yönlü bir etkisinin olduğunu belirtmişlerdir: Kaygı azaltıcı ve kaygı artırıcı etki. Sağlık kaygısı yaşayan bireylerin bu semptomlarının daha da içine girmelerinin nedenlerinden biri, bu kaygılarından aldıkları zevk olabilir. Sağlık kaygılı kişinin bilinçli veya bilinç dışı olarak, sağlıkla ilgili meslek seçiminden veya sağlıkla ilgili rutinlerinden zevk aldığı bir nokta bulunduğu görülmektedir.

Wahl (1963), sağlık kaygısı olan bireylerin hasta olmaktan zevk aldıkları izlenimi verdiklerini, çünkü çoğu zaman kendilerine verilen tedavilere karşı tepkisel olduklarını ve yapılan psikolojik ve fizyolojik açıklamaların kaygılarını da artırdığını söylemiştir. Katılımcılar görüşmelerde doktorlar tarafından kendilerine yapılan açıklamalara nasıl tepki verdiklerini ve verilen tedavilere ne derece uyum sağladıklarını anlatırken doktorla kurdukları ilişkiye vurgu yapmışlardır. Katılımcılar, tedavi eğer bilgisine güvenilmeyen bir doktordan geldiyse, uygulanan tedavilerin hiçbir etkisinin olmadığını hatta yan etkileri olduğunu veya önerilen tedaviye hiç uymadıklarını ve başka bir doktor arayışına girdiklerini dile getirmişlerdir. Benzer şekilde, tanı güvenmedikleri bir doktor tarafından kendilerine konulduysa, kanser gibi, sağlıkları hakkında ciddi kaygı duymalarına neden olan bir tanı konulmadıkça onun doğruluğuna inanmakta zorluk çekmektedirler. Bununla birlikte, tanı ve tedavi güvenebildikleri bir doktordan gelse bile, katılımcıların bir süreliğine rahatlama hissettikleri ancak sonrasında bedensel şikayetlerinin başka şekillerde devam ettiği gözlemlenmiştir. Bu nedenle, kaygı hissetme veya rahatlama hissinin süreleri değişse de, her katılımcı bir döngüden bahsetmektedir. Katılımcılar bedenlerinde yaşadıkları deneyimleri bir şekilde anlamalarına yardımcı olacak bilgiler aramaktadırlar ve bu temel olarak bu kişiler için bir teşhis almak olarak ortaya çıkmaktadır. Bu noktada, teşhisi Lacanyen anlamda “nesne a” olarak düşünmek mümkündür. Her ne kadar kişi, o “nesnenin” aradığı şey olduğuna ve bulduğunda kendisini tam hissedeceğine inansa da, “nesne a” doğası gereği sürekli kişiden kaçan bir şeydir (Burgess, 2017). Yukarıda açıklandığı gibi, katılımcılar bir tanı aldıklarında ancak kısa bir süre için rahatlıyor veya o tanının doğru olmadığını hissediyorlar gibi görünmektedir. Teşhis konulmasının rahatlatıcı etkisinin kısa süreli olması ve teşhinin yanlışlığı hakkındaki düşünceler, sağlık kaygısı olan kişiler için teşhisin “nesne a” olabileceği fikrini destelemektedir.

Katılımcıların çoğu bir tanı aldıklarında ve o tanının doğruluğuna inandıklarında, ilk başta bu “gerçek” durumla nasıl başa çıkacaklarına odaklandıklarından dolayı kaygı hissetmediklerinden söz etmişlerdir. Ancak konulan tanının yanlış olduğunu öğrendikten sonra, aldıkları tanı ile ilgili tedavi görmeye başladıktan sonra veya başka bir bedensel şikayet yaşadıktan sonra kaygılarının yeniden ortaya çıktığı görülmüştür. Bu durum, kaygının beklenti ile yakından ilgili olduğu düşüncesini örneklendirmektedir (Freud, 1926). Zaman zaman bazı katılımcılar yaşadıkları önemli olaylara sakince tepki verebildiklerini ve bunu hem kendilerinin hem de yakınlarının şaşırtıcı bulduğunu belirtmişlerdir. Bunlar, öznenin imgesel kastrasyon ile sürekli tehdit edilmesi nedeniyle kaygının egodaki imgesel yapıyla ilişkili olduğu fikrini desteklemektedir (Burgess, 2017).

Zevki acı olarak deneyimlemek, öznenin semptomlarından bilinç dışı olarak zevk alması ve aynı zamanda Freud tarafından hastalıktan elde edilen birincil kazanım olarak açıklanan

paradoksal duruma işaret etmektedir (Evans, 1996). Katılımcıların ilk önce kaygıyı azaltmaya yönelik olarak görünen ancak kaygıyı artıran düşünceler ve davranışlar içerisinde bulunmaları, bilinç dışı olarak semptomlarından zevk alıyor olmalarıyla ilişkilendirilebilir. Bu çalışmada, bu tür bir zevkin bilinç dışı olması nedeniyle katılımcılara doğrudan bir soru sorulamamış ancak katılımcıların görüşmelerde anlattıkları dikkate alarak bu konuda çıkarımlar yapılmıştır. Her şeyden önce, zevkin kaynağı hasta olmanın kendisi değil, hastalıkla ilişkilendirilen şeyler olarak düşünülmüştür. Öte yandan katılımcılar hasta olmakla ilgili endişelerini dile getirirken bir yandan hastalığı başkalarının bakımına bağımlı olmakla ve kendi kendilerine yetememe ile ilişkilendirdiklerini; ancak bir taraftan da bedensel şikayetleri ve kaygı hisleri nedeniyle etraflarındaki kişilerden nasıl bakım ve destek aldıklarını açıklamışlardır. Semptomların eş zamanlı olarak bağımlı olmaya yönelik hem korku hem de arzuyu bünyesinde barındırması ya da en azından yalnız kalmaya karşı bilinç dışı olarak koruyucu bir mekanizmasının olması dolayısıyla, katılımcıların hem bu semptomlarından şikayeçi olup hem de bu semptomları istemsiz bir şekilde besliyor olmaları mümkündür. Katılımcılar, ciddi bakım gerektiren kanser gibi kronik hastalıklar konusunda daha fazla kaygı duyup aynı zamanda da sürekli bu tür hastalıklara sahip olduklarını "hayal" etmektedirler. Bu, bu tür hastalıkların hem korkulan hem de istemeden arzu edilen şeyler olduğunun bir işareti olarak kabul edilebilir. Ayrıca, katılımcıların çoğu, semptomları nedeniyle kendilerini doktora götüren birisinin olduğundan veya yalnız kalmadıkları veya yalnız olmak istemedikleri bir durumda olduklarından bahsetmektedirler. Katıımcıların en büyük korkularından birinin işlevselliklerini kaybetme ve çalışamama gibi nedenlerle birine bağımlı kalmak olduğu düşünüldüğünde, bağımlı olma korkusunun, kendilerini hissettikleri anksiyete veya bedensel şikayetlerle başkalarına bağlamalarının eş zamanlı bir şekilde var olduğu söylenebilir.

Katılımcıların, aynı zamanda bir ruh sağlığı uzmanı olarak etkileşime girilen araştırmacı ile konuşurken, "*İnan abartıyor diye düşünme*", "*İnan ki"*, *"Gerçekten"* gibi ifadeler kullanmış olmaları dikkat çeken bir nokta olmuştur. Bu ifadeler, katılımcıların yaşadıkları zorluklara karşıdaki kişinin (karşıdaki kişi herhangi bir sağlık uzmanı olabilir) dikkatini çekmek için gösterilen bir çaba olarak değerlendirilmiştir. Katılımcıların bu iletişim tarzı, Lacanyen bakış açısına göre analizanın analisti var kılabilmek için yaptığı çağrıya benzer olarak, sağlık hizmeti veren profesyonelleri kendi yaşadıkları süreçlere dahil edebilmek adına yapılan bir çağrı olarak düşünülmüştür (Nasio, 1998).

Bir kesinliğe ulaşmak yerine soru sorma amacı taşıyan hipokondriya, aynı zamanda aşk/sevgi talebinde bulunmakla da ilişkilendirilen bir semptomdur. Bu nedenle, aşk ilişkisi içerisindeki bir kişinin hipokondriyak kaygılarında bir artış olması beklenir, ancak genellikle bunun tam tersi ile karşılaşılmaktadır: Kişi bir aşk ilişkisi içerisinde olmadığında şikayetleri artmaktadır (Leader,

2004). Katılımcıların romantik ilişkileri ile hipokondriyak şikayetleri arasındaki ilişki göz önüne alındığında, hem bir ilişkisi içinde olan hem de bir ilişki içinde olmayanlar için hipokondriyak kaygıların var olduğu görülmektedir. Evli katılımcılar genellikle eşlerinin kendilerinin bedensel şikayetleriyle yeterince ilgilenmediklerini ifade etmişlerdir. Bedensel şikayetlerin aşk için bir talep olduğu görüşü göz önünde bulundurulduğu durumda, bu ilişkinin kişi için ne kadar tatmin edici olduğunun bedensel şikayetlerin artması veya azalması üzerinde çok etkili bir rol oynadığı söylenebilir. Diğer bir ifadeyle, bir insanın romantik bir ilişki içinde olup olmaması tek başına bir anlam ifade etmiyor gibi görünmektedir. Partnerlerinden herhangi bir şikayeti olmayan katılımcıların bedensel şikayetlerinin sürekliliği ise, aşağıdaki "hasta olmanın / hissetmenin faydaları" bölümünde açıklandığı gibi bedensel şikayetlerden alınan ilginin sürekliliğini sağlamakla ilgili olabilir.

4.3. Her Şerde Bir Hayır Vardır: Hasta Olmanın/Hasta Hissetmenin Faydaları

Stuart ve Noyes (1999) çocuklukta kaygılı bağlanma stiline sahip olmak ile yetişkinlikte somatik belirtilerin olmasını ilişkilendirerek; çocuğun art arda hastalandığı bir durumda, kendisine bakım veren kişinin ihtiyaçlarına cevap vermemesinin yetişkinlikteki sağlık davranışları üzerinde bir sonucu olabileceğini söylemişlerdir. Yetişkinlikteki somatizasyonu, dolaylı olarak güvenlik hissini geri kazanmanın bir parçası olarak karşıdaki kişiden ilgi almaya çalışmak olarak açıklamışlardır. Ancak Stuart ve Noyes'in aksine çoğu katılımcı, kaygılı ebeveynlerinin çocukken (ve çoğu zaman da şimdiki zamanda da) kendilerinin üzerlerine ne kadar düştüğünden söz etmişlerdir. Ayrıca, çalışmanın bu bulgusu hipokondri üzerine yürütülen nitel bir çalışmanın bulgularından da farklılaşmıştır. Papis (2015), çalışmasındaki katılımcıların duygusal ihtiyaçlarının ebeveynleri tarafından karşılanmadığını bulmuştur ancak şimdiki çalışmada yer alan katılımcılar bunun aksine işaret etmişlerdir. Bu nedenle somatizasyonun ortaya çıkması ve sürekliliği için önemli faktörlerden birinin, kişinin hasta olduğunda ilgi ve bakım alamaması olmadığı, tam tersine bedensel şikayetlerin sonuçta ilgi ve bakım getirmesi olduğu sonucuna varılabilir.

Sağlık kaygısının bir başka faydası, kişinin hayatındaki diğer problemlerle baş etmesinin bir yolu olması olarak ortaya çıkmıştır. Bu durum aşina olunan, tanıdık semptomların, yani bu durumda somatik semptomların ve bu semptomlar ile igili hissedilen kaygının, kişinin nasıl başa çıkacağını bilmediği diğer durumlardan daha fazla tercih etmesiyle açıklanabilir.

Kirmayer ve Young'un (1998) makalelerinde belirttikleri gibi, somatizasyon bazı özellikleri ve yaygınlığı kültürden kültüre değişse de tek bir kültüre özgü değildir; aksine, dünya çapında duygusal bir sıkıntıyı, üzüntüyü ifade etmenin en yaygın yoludur. Somatik belirtilerin kendilerini

psikolojik olarak iyi hissetmedikleri zaman arttığını söyleyen katılımcılar da bu bilgiyi doğrulamaktadır. Kirmayer ve Young (1998), hastalıkla ve iyileşme ile ilgili kullanılan dilin, nasıl bir tıbbi gelenek içerisinde kullanıldığına bağlı olduğunu söylemişlerdir. Bazı görüşmelerde katılımcılar somatik şikayetlerini veya kaygılarını ifade etmek için “rahatsızlık” kelimesini kullanmayı tercih etmişlerdir. Türkçede, bu kelimenin ilk anlamı rahatsız olma durumu, tedrginlik iken, ikinci anlamı hastalıktır. Bu nedenle, Türkçe'deki “rahatsızlık” kelimesi bir şekilde psikolojik sıkıntıyı içerisinde barındırmaktadır. Türkçe'de fiziksel problemlerle psikolojik problemler arasındaki ilişki kelimelerin anlamlarına yansımış durumdadır. Freud fiziksel belirtilerin ego tarafından kendisini dış tehditlerden korumak ve rahatlamak amacıyla meydana getirildiğini iddia etmektedir ve onun bu düşüncesi fiziksel problemlerle psikolojik problemler arasındaki ilişkinin bir açıklaması olabilir (Sata ve Munday, 2017).

Katılımcıların açıklamaları, sağlıkla ilgili sorunların yaşanmasının bir sonucu olarak, önceliklerinin nasıl değiştiğini ve sağlık konusunun nasıl diğer her şeyi gölgede bıraktığını göstermiştir. Bu Segall'in (1976) anlattıklarıyla tutarlı bulunmuştur. Ona göre, insanlar hasta olduklarını düşündüklerinde ve hastalık rolünü benimsediklerinde, gündelik faaliyetlerinden muaf olma hakkına sahip olmaktadırlar. Katılımcıların öz bakımlarının, kendilerini kabullerinin ve kendilerine verdiği değerin artması, sağlıklarını her şeyin üzerinde tutmanın sonucu olarak gözlemlenmiştir. Bu, ben merkezli olmanın hipokondriyak semptomları olan bireyler tarafından paylaşılan bir özellik olduğu fikri ile de tutarlıdır (Fenichel, 2005). Katılımcıların sosyoekonomik seviyelerinin, hastalığın ne gibi sorumluluklardan muaf tuttuğu konusunda bir fark yarattığı görülmüştür. Eğitim düzeyi ve ekonomik durumu göreceli olarak düşük olan katılımcılar için hasta olmak veya hasta hissetmek ev işi yapmama konusundaki sorumluluklarını azaltırken, sosyoekonomik durumu yüksek katılımcılar için hastalık, akademik sorumluluklar açısından daha fazla rahatlık sağlamıştır. Ayrıca, hastalık nedeniyle başarısız olunan şeylerle ilgili hissedilen sorumluluklardan kurtulunması, suçluluk duygularının azalmasına neden olmuştur. Literatüre göre, sıkıntıyı duygusal zorluklar yerine somatik nedenlere atfetmek, kişiyi kontrol kaybı hissetmekten ve psikiyatrik tanıların benlik saygısı üzerindeki olumsuz etkilerinden korumaktadır (Kirmayer ve Young, 1998). Bu, katılımcıların suçluluk duygularındaki azalmanın bir açıklaması olabilir. Sonuç olarak, sorunları bedenselleştirmenin kişi için koruyucu bazı etkilerinin olduğu düşünülerek, kişilere problemlerinin kaynağının psikolojik olduğunu gösterme çabalarının fayda-zarar dengesini göz önünde bulundurması gerektiği ortaya çıkmaktadır.

4.4. Dört Temanın Birbirleriyle İlişkisi

Her ne kadar hipokondriya hakkında bir model üretmek bu çalışmanın amacı olmasa da, bulunan dört tema ve bu temaların birbirleriyle olan ilişkileri, diğer nitel ve nicel araştırma yöntemleriyle daha fazla araştırılması gereken geçici bir model ortaya koymuştur. Görüşme sonuçlarından elde edilen bulguları şu şekilde özetlemek mümkündür: Sağlık kaygısı, bir insanın kayıplarla başa çıkamaması neticesinde kendisine etrafında kendisini örgütleyebileceği bir şey sağlar. Daha sonra sağlık kaygısı olan kişi, bu kaygının hem devamlılığını sağlayan hem de onu yok etmeye yönelik birtakım eylemler gerçekleştirir. Hasta olmakla ilgili kaygılanmanın ya da hasta hissetmenin bilinç dışı getirileri ve kişinin farkında olduğu faydaları tüm bu eylemleri kapsayacak şekilde merkezdedir.

4.5. Genel Tartışma

Hipokondriyak semptomların sınıflandırılması tartışmalı bir konudur. DSM-V'de, hipokondriya yerine, iki yeni tanı kategorisi eklenmiştir. Bedensel belirti bozukluğu ve hastalık kaygısı bozukluğu olmak üzere bu iki kategoriyi oluşturmanın mantığı; bedensel semptomları, fiziksel semptomları olmadan hastalık konusunda kaygı hissetmekten ayırt etmeye dayanıyordu (APA, 2013). Görüşmelerde böylesi bir ayrımın sorunlu olduğunu gösteren bir biçimde, bu iki "ayırt edici" kategori iç içe geçmiş bir haldedir. Katılımcıların çoğunda, doktorlar tarafından teşhis edilen ya da bazen de doktorların tanı koymadığı ancak kişiler tarafından hissedilen baş ağrıları, çeşitli ağrılar veya yaralar gibi bedensel şikayetlerin olduğu görülmüştür. Ayrıca, DSM tarafından tanıları sınıflandırmak için benimsenen "steril" yaklaşım, sağlık kaygısı olan bireylerin panik bozukluk ve takıntı gibi diğer bazı kategorilerle de yüksek eş zamanlılık (komorbidite) gösterdiği düşünüldüğünde sorunlu bir hal almaktadır.

Çalışmanın amaçlarından biri, sağlık kaygıları olan bireylerin bedenlerini nasıl algıladıklarını anlamak olarak belirlenmiştir. Katılımcıların bedenleri hakkındaki açıklamaları, temaları netleştirmek amacıyla verilen alıntılarda zaman zaman yer almaktadır; ancak bu açıklamalar yeterince güçlü bir tema olarak ortaya çıkmadığı için ayrı bir tema oluşturulamamıştır. Bunun bir nedeni, spesifik olarak sorulmadıkça katılımcıların kendi bedenlerini nasıl algıladıkları veya bedenleriyle nasıl ilişki kurdukları hakkında herhangi bir bilgi getirmemiş olmalarıdır. Ayrıca, "Bedeniniz sizin için ne anlam ifade ediyor?" sorusu, katılımcıların anlamakta ve cevap vermekte en fazla zorluk çektiği soru olmuştur. Yine de beden, sağlık kaygısının önemli bir parçası olduğundan, bunun hakkında bir tartışma yapmak önemli olmaktadır. Her ne kadar katılımcılar bedenlerini fiziksel bir bedeni tanımlıyormuş gibi tanımlamaya çalışsalar da, ifadeleri bedenlerinden beklentileri olduğuna ve bu beklentiler gerçekleşmediğinde hayal

kırıklığına uğradıklarına, bedenlerini korumaları gereken bir şey olarak gördüklerine, bazen de bedenlerini kontrol edilemez bir şey olarak algıladıklarına işaret etmektedir. Bedenin bu şekilde tanımlanması, her katılımcının bedenlerine kişisel bir anlam verdiğini söylemeyi mümkün kılmakta, bedenin Freud ve Lacan'ın da önerdiği gibi yalnızca fiziksel bir varlık olmadığı fikrini desteklemektedir (Burgoyne, 2004; Gessert, 2004).

Hastalığın ne anlama geldiğini yorumlamaları açısından katılımcının cinsiyetinin bir fark yaratmadığı gözlemlenmemiştir. Hastalıkları itibarın ya da işlevselliğin kaybıyla ve güçsüzlükle ilişkilendirmek hem erkek hem de kadın katılımcıların dile getirdikleri bir bağlantı olmuştur. Cinsiyetler arasında böyle bir farkın olmamasının nedeni, görüşme yapılan kadınların çoğunun yüksek eğitim seviyesine ve bir kariyere sahip olması olabilir. Daha da önemlisi, kadınlık ya da erkeklik, bir insanın biyolojik konumuna işaret etmek yerine kendini nasıl konumlandırdığıyla ilgilidir (Stets ve Burke, 2000) ve cinsiyet kimliği, cinsiyetin kendisinden daha etkili bir role sahip görünmektedir.

4.6. Çalışmanın Güçlü Yönleri ve Sınırlılıkları ve Bulguların Klinik Açıdan Önemi

Katılımcılar sahip oldukları hastalıklarla ya da hasta olmaya yönelik duydukları kaygıyla ilgili konuşmakta zorlanmamışlar; hatta çoğunlukla kendilerini tanıtmaları istendiğinde direk bu konu üzerinden konuşmaya başlamışlardır. Öyle ki, bu durum sağlık kaygısı olan kişilerin hastalıklar üzerinden konuşarak ilişki kurduklarının ve aktarımlarının bu anlamda hızlıca geliştiğinin bir göstergesi olarak değerlendirilmiştir. Katılımcıların araştırmanın konusu hakkında konuşmakta rahat olması, onlarla yalnızca tek bir görüşme yapılmış olmasının getirdiği dezavantajları kısmen ortadan kaldırmıştır. Yine de, ilk görüşmenin katılımcı üzerindeki etkisinin neler olduğunu görebilmek, üzerinde daha fazla konuşmanın gerekli olduğu düşünülen konuları detaylandırmak, ağırlıklı olarak hastalıklar çerçevesinde konuşulan ilk görüşme sonrasında katılımcıların neler hakkında daha fazla konuşmak isteyeceklerini gözlemlemek adına en azından ikinci bir görüşme yapılmamış olması çalışmanın bir kısıtlılığı olarak değerlendirilmiştir.

Hipokondriyak şikayetleri olan kişiler, hem tıp doktorları hem de ruh sağlığı çalışanları ile sıklıkla karşı karşıya gelmektedir. Doktorların bu kişilerin yalnızca fiziksel semptomları kısmıyla ilgilendiğini düşünmek doğru olmayacaktır. Uzmanlar tarafından yapılan fiziksel hastalık-psikolojik bozukluk ayrımının, hipokondriyak şikayeti olan kişilerin gerçekleriyle uyuşmadığı görülmektedir. Bu kişiler, sahip olduklarını düşündükleri hastalığın fizyolojik bir temeli olmasa bile varmış gibi deneyimlemektedirler. Katılımcılar doktorlardan beklentilerinin neler olduğunu açıklarken doktorların bilgi düzeyine atıf yapmış olsalar da, aynı zamanda

doktorların kendilerini ne kadar anladıkları, empatik olup olmadıkları, kendisini geçiştirip geçiştirmedikleri gibi ilişkisel noktalara da vurgu yapmışlardır. Ayrıca görüşmelerdeki ifadelerden ortaya çıkan önemli bir nokta da katılımcıların güvenmedikleri, iyi ilişki kuramadıklarını düşündükleri doktorların verdiği tedaviyi uygulamamaları, uyguladıklarında ise tedavinin yan etkilerinden söz etmeleri olmuştur. Dolayısıyla bu çalışma doktor ve hasta arasındaki ilişkinin önemini göstererek, yalnızca ruh sağlığı çalışanları için değil, sağlık kaygısı şikayeti olan kişilerle çalışan her meslek elemanı için önemli bulgulara işaret etmektedir.

Buna ek olarak, hipokondriyak şikayetleri olan kişilerle çalışılırken, katılımcıların sağlık kaygılarının ortaya çıkışıyla ilişkilendirerek anlattıkları kayıp konusunda üzerinde durmanın önemi ortaya çıkmıştır. Kaybın sembolize edilememiş olmasının hipokondriya için önemli olduğu göz önünde bulundurulduğunda, kişilerin kayıpla ilgili konuşmalarına olanak sağlamanın somatizasyonu azaltacağı düşünülmektedir. Çalışmanın kapsamı gereği psikotik yapıda olan ve hipokondriyak şikayetlere sahip kişilerle görüşülmemiştir. Dolayısıyla yalnızca hipokondriyak semptomlarının delüzyonel özelliklere sahip olmadığı kişiler için bu şekilde bir öneride bulunmak mümkündür.

Son olarak, bu çalışma, bedensel şikayetlerin psikolojik faktörlerle ilişkisine dikkat çekme girişiminin, çoğu katılımcının kendisinin bunu halihazırda ifade ettiği düşünüldüğünde, hiçbir etkisi olmayan, gereksiz bir müdahale olabileceğini göstermiştir. Ayrıca, katılımcılara sağlık durumları ile ilgili verilen bilgilerin rahatlatıcı etkisinin kısa vadeli olduğu ve “Bende yanlış olan ne?” sorusunun döngüsel bir şekilde devam ettiği göz önüne alındığında, tedavinin odağının bedensel belirtilerin ciddi bir duruma işaret etmediğine dair bilgi sağlamak olmaması önemli bir bulgu olarak ortaya çıkmıştır. Aslında bu kişiler için esas olan bulmak değil aramanın kendisidir. Sonuç olarak hipokondri hastaları ile çalışan terapistler, hasta ile terapötik bir ittifak kurduktan sonra, bu kişilerin kendilerinde ne olduğunu bilme isteklerinin sürekliliğini anlamalarına yardımcı olmalıdır.

APPENDIX H: TEZ İZİN FORMU/ THESIS PERMISSION FORM

ENSTİTÜ / INSTITUTE

Fen Bilimleri Enstitüsü / Graduate School of Natural and Applied Sciences ☐

Sosyal Bilimler Enstitüsü / Graduate School of Social Sciences ■

Uygulamalı Matematik Enstitüsü / Graduate School of Applied Mathematics ☐

Enformatik Enstitüsü / Graduate School of Informatics ☐

Deniz Bilimleri Enstitüsü / Graduate School of Marine Sciences ☐

YAZARIN / AUTHOR

Soyadı / Surname : BULUT

Adı / Name : BURCU PINAR

Bölümü / Department : PSİKOLOJİ

TEZİN ADI / TITLE OF THE THESIS (**İngilizce** / English) : A HELIX OF ANXIETY: A QUALITATIVE ANALYSIS OF THE PERSONAL EXPERIENCES OF INDIVIDUALS WITH HEALTH ANXIETY

TEZİN TÜRÜ / DEGREE**:** **Yüksek Lisans** / Master ☐ **Doktora** / PhD ■

1. **Tezin tamamı dünya çapında erişime açılacaktır. /** Release the entire work immediately for access worldwide. ■
2. **Tez iki yıl süreyle erişime kapalı olacaktır.** / Secure the entire work for patent and/or proprietary purposes for a period of **two years. *** ☐
3. **Tez altı ay süreyle erişime kapalı olacaktır.** / Secure the entire work for period of **six months**. ***** ☐

***** *Enstitü Yönetim Kurulu kararının basılı kopyası tezle birlikte kütüphaneye teslim edilecektir.*

A copy of the decision of the Institute Administrative Committee will be delivered to the library together with the printed thesis.

Yazarın imzası / Signature ..... **Tarih** / Date ……